

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 24

00611

1. PLACE OF DEATH:

County Montgomery
 City or town Kensington
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
 Hospital, residence, or street address where death occurred:
10 Knowles Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Kensington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 10 Knowles Ave.
 (If rural, give LOCATION)

2.(a) If veteran, name war no

3. (a) FULL NAME

Mrs. Margaret Darby Adams

3. (b) Social Security Number

none

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife James Hopkins

7. Birth date of deceased (mo., day, yr.) Oct. 11th. 1871 8. (c) If alive, give age _____ years

8. AGE: Years 76 Months 3 Days 4 If less than one day _____ hrs. _____ min.

9. Birthplace South Carolina
 (Town, county, and state)

10. Usual occupation Retired Housewife

11. Industry or business

12. Name Elliott Darby13. Birthplace S. C.14. Maiden name Deas Sinkles15. Birthplace S. C.16. Informant Dr. Chas. E. R. AdamsAddress 10 Knowles Ave. Kensington

17. Burial Date thereof Jan. 18 '48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Johns CemeteryLocation Congaree, S. C.

18. Funeral director Walter E. Humphrey, Inc.
 Address Silver Spring, Md.

19. Jan. 16 1948 Josephine M. Schaeffer
 (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/15/48 1948 at 12:50 P.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1947 1947 to 1/15/48 1948
 and that I last saw him alive on 1/15/48 1948

Immediate cause of death

DURATION

Hemorrhage, Central 2 weeks
arterio-sclerotic, hypertensive years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Kensington, Md. Date signed 1/16/48

RECEIVED

JAN 20 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00612

Reg. Dist. No. 216

1. PLACE OF DEATH: Montgomery
 County Bethesda (rural)
 City or town Bethesda (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State D.C. County Washington
 City or town Washington (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3500 14th St., N.W., Cavalier Hotel
 (If rural, give LOCATION)
 2(a) If veteran, name war ✓

3. (a) FULL NAME

APPLEBY, Laura Viola

3. (b) Social Security Number

4. Sex female 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Thomas Appleby
 6. (c) If alive, give age 20 years
 7. Birth date of deceased (mo., day, yr.) September 26, 1893
 8. AGE: Years 54 Months 3 Days 18 If less than one day hrs. min.

9. Birthplace Pa. (Town, county, and state)
 10. Usual occupation housewife
 11. Industry or business
 12. Name GRAVES, Luther Pa.
 13. Birthplace Pa.
 14. Maiden name CROSS, Fanny L.
 15. Birthplace Pa.

16. Informant husband: Mr. Thomas Appleby
 Address 3500 14th St., N.W., Cavalier Hotel, D.C.
 17. burial Date thereof 1-19-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Arlington National
 Location Arlington, Va.
 18. Funeral director S. H. HINES C.M.S.
 Address 2901 14th St., N.W., Wash., D.C.
1-15 48 Mary C. Patterson
 19. (Date rec'd by registrar) 19 48 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 January 19 48 at 9:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
10 January 19 48 to 10 January 19 48
 and that I last saw h. er alive on 14 Jan 19 48

Immediate cause of death Congestive Heart Failure

DURATION

1 mo.

Due to Rheumatic Heart Disease, 20 yrs.
mitral stenosis.

Due to Purulent Pericarditis & effusion 1 wk.
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

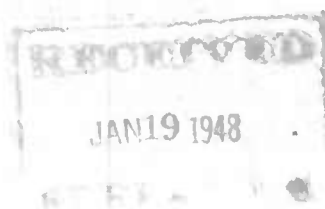
22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE H. C. FOWLER, Jr., Lt. Cdr. USN
J. J. Fowler
 M. D. or other USNH Bethesda, Md.
 Address _____ Date signed 1-15-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban HospitalHow long in hospital or institution? 8 1/2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Cherry Chase
(If outside city or town limits, write RURAL and give nearest town)Street No. 19 Dorset Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Joanna Barnes

3. (b) Social Security Number

4. Sex female5. Color or race white6. (a) Single, married, widowed, or divorced widow6. (b) Name of husband or wife Clair (deceased)7. Birth date of deceased (mo., day, yr.) Sept. 16, 1870

5. (c) If alive, give age years

8. AGE: Years 77 Months 3 Days 21 ft less than one day hrs. min.9. Birthplace Jersey Ohio
(town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Ralph Pierson13. Birthplace Ohio14. Maiden name Sarah Howe15. Birthplace Ohio16. Informant James A. Barnes (son)Address Same17. Burial Date thereof Jan 9, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Fort LincolnLocation Bladensburg Md.18. Funeral director Deal Funeral HomeAddress 4812 Ga Ave NW19. 1/7 19 48 W F Jones Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan-6, 19 48 at 9:02 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 11, 1947, to January 6, 1948and that I last saw her alive on January 6, 1948

Immediate cause of death

Respiratory failureDue to Diabetic ComaDue to Diabetes mellitus

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

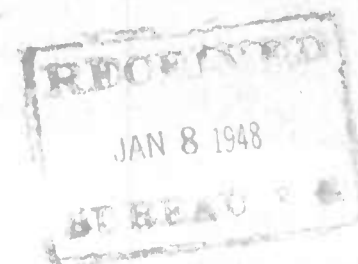
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank Y. Jagger, Jr. M.D.Address 5707 W. 5th Ave NW Date signed 1/7/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? died enroute Naval Hospital
 Hospital, institution, or street address where death occurred:
Bethesda, Md.
 How long in hospital or institution? died enroute

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Calif. County _____
 City or town Long Beach
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1200 East 10th St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war WWII

3. (a) FULL NAME

Howard Bartholomew BECKWITH

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Jane Young Beckwith
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) February 11, 1908

8. AGE: Years 39 Months 10 Days 30 If less than one day _____ hrs. _____ min.

9. Birthplace Colo.
 (Town, county, and state)

10. Usual occupation US Navy

11. Industry or business

12. Name BECKWITH,

13. Birthplace unknown

14. Maiden name unknown

15. Birthplace unknown

16. Informant Wife: Mrs. Jane Y. Beckwith

Address 1406 Donald St., Jacksonville, Fla.

17. burial Date thereof 1-22-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____

Location Long Beach, Calif.

18. Funeral director W. W. CHAMBERS W. J. T.

Address 1400 Chapin St., N.W., Wash. D.C.

19. 1-12-48 19 _____
 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 January 19 48 at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
DEPUTY MEDICAL EXAMINERS CASE
 and that I last saw him alive on _____ 19 _____

Immediate cause of death _____ DURATION _____

Subarachnoid hemorrhage 2 mo.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

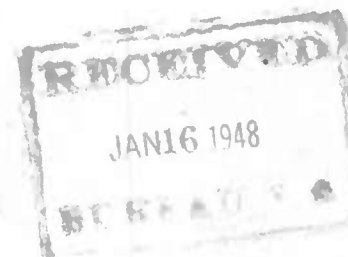
Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Frank J. Prochant M.D. M. D. or other

Address San Francisco Md Date signed 1-11-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

942

00615

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH:

County Montgomery
City or town Taboma Park, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? few minutes

Hospital, institution, or street address where death occurred:

Wash. San. Hosp. Taboma Park 12 Md.

How long in hospital or institution? few minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Wash. D.C. County

City or town 2530 Warder St. NW
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Rachel Rose Bengel

3. (b) Social Security Number

4. Sex Fe. 5. Color or race Cauc 6. (a) Single, married, widowed, or divorced Divorced

6. (b) Name of husband or wife William C Bengel

Divorced 6. (c) If alive, give age 2 years

7. Birth date of deceased (mo., day, yr.) 1865--

8. AGE: Years 82 Months 1 Days 12 If less than one day hrs. min.

9. Birthplace Wash. D.C.
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

12. Name John Goodman

13. Birthplace Bladensburg, Md.

14. Maiden name Mary Swain

15. Birthplace Bladensburg, Md.

16. Informant Mrs. William C Bengel

Address 419 Ethan Allen Ave Trk PK Md

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Evergreen Cemetery

Location

18. Funeral director Francis Gasch

Address Wyattsville

19. Jan 20 19 48

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20 19 48 at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Def. med. Exam case 19 to 19

and that I last saw h alive on 19

Immediate cause of death Coronary occlusion

Due to subd

Due to subd

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Brochait M.D.

Subd. Exam M. D. or other

Address Bladensburg Md Date signed 1/20/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-5M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2228P. D. 22.

RECEIVED

JAN 22 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 714

00616

1. PLACE OF DEATH:

County Montgomery
 City or town Bathurstburg md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Montgomery
 City or town Bathurstburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. none
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME EMANUEL BENJAMIN

Benjamin Emanuel

3. (b) Social Security Number

none

4. Sex M 5. Color or race C 6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife Mariah Benjamin

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age 5-6 years

8. AGE: Years 55 Months 1893 Days hrs. min.

9. Birthplace Sumpter So. Carolina
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Frank Benjamin
 13. Birthplace So. Carolina

14. Maiden name Francis Wilton
 15. Birthplace So. Carolina

16. Informant Gabriel Benjamin
 Address 1022-5th St N.E.

17. 1-14-48 Date thereof. (month) (day) (year)
 (Burial, cremation, or removal. Which?)

Cemetery or crematory Church Cemetery
Sumpter County.

18. Funeral director Montgomery Brothers
 Address 913 Fld Avenue

19. Jan 10 19 48 Josphine M Schaeffe
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10 19 48 at 12:55 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 14 19 47 to Jan 9 19 48
 and that I last saw him alive on Jan 9 19 48

Immediate cause of death Disseminated intravascular coagulation

DURATION

Due to Amputation of Brain

Due to

Other conditions Diabetes Mellitus
& Hypertension
 (Include pregnancy within 3 months of death)

Major findings of operations none Date of op. none

Autopsy results none
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide NO Date of none

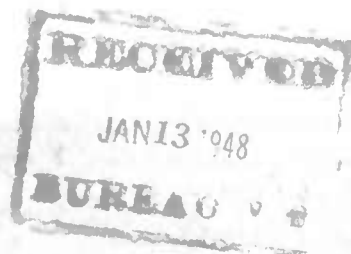
Where did injury occur? none (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) NO

Means of injury none Injured at work?

23. SIGNATURE Wm. J. Schaeffe M.D. or other
Wm. J. Schaeffe Date signed Jan 10 1948

005975



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Montgomery
City or town Brookville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD County Balto County
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. 109 E Burke Ave
(If rural, give LOCATION) ✓
2.(a) If veteran, name war.....

3. (a) FULL NAME

Mallie S. Bosley

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced Widowed
B.(b) Name of husband or wife Robert E Lee Bosley
deceased 6.(c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.) November-26-1868
8. AGE: Years 79 Months 2 Days - If less than one day 4 hrs. 30 min.

9. Birthplace Baltimore County
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name William T. Musgrove

13. Birthplace Maryland

14. Maiden name Mary Ann Greaser

15. Birthplace Maryland

16. Informant Mrs James Bosley Ziegler

Address Brookville, Montgomery Co. Md.

17. Burial, cremation, or removal. Which? Burial Date of death Jan. 29-1948
(month) (day) (year)

Cemetery or crematorium Prospect Hills

Location Towson, Maryland

18. Funeral director Burke Funeral Home

Address 3631 Fells Road

19. Jan 28 19 48 A. W. Hedrick
by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26 19 48 at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 19 47 to January 26 19 48

and that I last saw her alive on January 26 19 48

Immediate cause of death Chronic Myocarditis

Due to..... DURATION 2 yrs

Due to.....

Due to.....

Other conditions Chronic Valvular Heart Disease 5 years

arthritis

(Include pregnancy within 3 months of death)

Major findings of operations.....

Antopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Mark J. Ziegler M.D.

M. D. or other Brookville Md

Address..... Date signed 1/26/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-3M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00618

CERTIFICATE OF DEATH 69

Reg. Dist. No. 218

1. PLACE OF DEATH:

County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days 23 hrs 17 min.
Hospital, institution, or street address where death occurred:
Washington San & Hosp. Takoma Park
How long in hospital or institution? 2 days 23 hrs 17 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State md. County Montgomery
City or town Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Mr Earnest Bowman.

3. (b) Social Security Number

4. Sex m. 5. Color or race white 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) July 19-1880 6. (c) If alive, give age _____ years

8. AGE: Years 67 Months 5 Days 21 If less than one day 10 hrs. 17 min.

9. Birthplace Howard Co. Md.
(Town, county, and state)

10. Usual occupation Handyman.

11. Industry or business 1

12. Name Chester C. Bowman

13. Birthplace Gaithersburg

14. Maiden name Annie Wallick

15. Birthplace Germantown Md.

16. Informant Hosp. Records

Address Washington San & Hosp Takoma Park

17. Burial Burial Date thereof 11/12/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Forest Oak Cemetery

Location Gaithersburg Md.

18. Funeral director James A. Carter

Address Gaithersburg Md.

19. Jan 11 1948 Charles J. Cooke
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-9-48 at 10:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-7-48 to 1-9-48 and that I last saw him alive on 1-9-48

Immediate cause of death Rotar pneumonia DURATION Terminal

Due to Malnutrition ?

Due to alcoholism ?

Other conditions Polluxia ?

Chr Nephrosclerosis ?
(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results Conferin above Date of op. _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert A. Hare M.D.

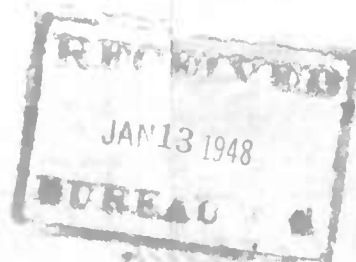
Address Takoma Park Md. M. D. or other _____

Date signed 1/9/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH:

County Montgomery
City or town Takoma Park, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 31 days
Hospital, institution, or street address where death occurred:
Washington Sanitarium & Hospital
How long in hospital or institution? 31 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Dist. of Col. County _____
City or town Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 16303 9th St. N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war. _____

3. (a) FULL NAME

Bramlett, Mr. Jay Mims

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1869

8. AGE: Years Months Days If less than one day
78 3 19 hrs. min.

9. Birthplace Greenville, S.C.
(Town, county, and state)

10. Usual occupation SS Officer at White House

11. Industry or business Retired

12. Name Robert Bramlett

13. Birthplace Greenville, S.C.

14. Maiden name Amelia Holland

15. Birthplace Greenville, S.C.

16. Informant Wash. San. & Hosp. Records

Address Takoma Park, Maryland

17. Burial Date thereof Jan 13th 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fleming Cemetery

Location Lincoln Rd. Washington, D.C.

18. Funeral director The S. W. Hines Co.

Address 2901-14th St. N.W.

19. Jan. 11 - 1948 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11, 1948 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-11-47 to 1-11-48 and that I last saw him alive on 1-11-48

Immediate cause of death Multiple Pulmonary Infarcts DURATION 2 days

Due to Congestive Cardiac Failure ?

Due to Atherosclerosis ?

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results Verify above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert A. Hare M.D.

Address Takoma Park, Md. Date signed 1/11/48

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Do not correct age in especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

00620

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Rural - Bethesda
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Six weeks
 Hospital, institution, or street address where death occurred:
Pine View Rest Home
 How long in hospital or institution? Six weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington - D.C. County Tilden
 City or town Washington - D.C.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4930 - Tilden
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

AGNES REDFIELD BRENTON

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Henry N. Brenton
 7. Birth date of deceased (mo., day, yr.) Feb 5 - 1864 8. (c) If alive, give age 83 years
 8. AGE: Years 83 Months 0 Days 0 If less than one day 0 hrs. 0 min.

9. Birthplace Cook County, Ill.
 (Town, county, and state)

10. Usual occupation —11. Industry or business —

MOTHER FATHER
 12. Name James Redfield
 13. Birthplace N.Y.

14. Maiden name Cora Kennicott
 15. Birthplace Ill.

16. Informant John Brenton
 Address Billings, Mont

17. Cremation Date thereof 1-9-48
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill
 Location Suptlands Md.

18. Funeral director Joseph Dawkins Son, Inc.
 Address 1736 Penn Ave.

19. 11-8 48 Wm E Jones
 (Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 Jan 19 48 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 47 to 7 Jan 19 48
 and that I last saw him/her alive on 7 Jan 19 48

Immediate cause of death Cerebral Thrombosis DURATION 2 weeks
Arteriosclerotic Cardio Vascular Disease 10 years
 Due to Arteriosclerosis generalized approx 10 yrs

Due to —Other conditions —

(Include pregnancy within 8 months of death)

Major findings of operations —Date of op. —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —

23. SIGNATURE H.A. Brennan M.D.
 M. D. or other

Address 1150 Connecticut Ave Date signed 8 Jan 47

RECEIVED

JAN 15 1948

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00621

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 13 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 2 months, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Tenn. County _____
City or town Memphis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1019 Looney
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

BRIGNOLE, Stephen Richard, Pfc USMC

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced single
6.(b) Name of husband or wife _____
7. Birth date of deceased (mo., day, yr.) December 29, 1928
8. AGE: Years 19 Months 0 Days 9 If less than one day _____ hrs. _____ min.

9. Birthplace Tenn.
(Town, county, and state)
10. Usual occupation Marine Corps
11. Industry or business _____
12. Name BRIGNOLE, Steve dec
13. Birthplace Tenn.
14. Maiden name PIERONTONI, Lorena
15. Birthplace Tenn.

16. Informant Mo: Mrs. Lorena Brignole
Address 1019 Looney, Memphis, Tenn.
17. burial Date thereof _____ (month) (day) (year)
(Burial, cremation, or removal, Which?)
Calvary
Cemetery or crematory _____
Memphis, Tenn.
Location _____
18. Funeral director W. W. CHAMBERS
Address 1400 Chapin S., N. W. Wash., D.C.
Mary C. Patterson
19. 1-8- 48 Mary C. Patterson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 January 48 at 2:05 P
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 25 47 to 8 January 48
and that I last saw him alive on 8 January 48
Immediate cause of death Hypernephroma, left kidney
DURATION _____
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings of operations _____
Date of op. _____
Autopsy results confirmed above
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____
23. SIGNATURE J. A. MURPHY, Cdr. MC USN
Address USNH Bethesda, Md. Date signed 1-8-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 10 1948

ST. PAUL V. C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00622 216

1. PLACE OF DEATH:

County Montgomery
City or town Potomac
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 daysHospital, institution, or street address where death occurred:
(None-Street) Pine View HomeHow long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County MontgomeryCity or town Montrose
(If outside city or town limits, write RURAL and give nearest town)Street No. R.F.D. Rockville
(If rural, give LOCATION)2.(a) If veteran, name war None

3. (a) FULL NAME

JULIA F. BROWN

3. (b) Social Security Number

None4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Andrew P. Brown8. (c) If alive, give age 67 years7. Birth date of deceased (mo., day, yr.) May 31, 18838. AGE: Years 65 Months 6 Days 2 If less than one day - hrs. - min.9. Birthplace Caroline County, Virginia
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Home12. Name Samuel O. W. Beall13. Birthplace Sugar Loaf Mountain, Md.14. Maiden name Mary Ellen Beckett15. Birthplace Caroline County, Virginia16. Informant Andrew P. Brown (husband)Address Montrose, Maryland17. Burial Date thereof Jan. 6, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rockville Union CemeteryLocation Rockville, Maryland18. Funeral director Wm. R. RumpseyAddress Rockville, Maryland19. 1/5/48 19. Wm E Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 3rd 48 at 4:15 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 45 to January 3 48and that I last saw her alive on January 3rd 48Immediate cause of death RespiratoryfailureDue to Carcinoma of theuterusDue to metastatic lesionsthroughout

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Rogers Jr. M.D.Address 5707 Wicomico Rd Date signed 1/5/48

MARGIN RESERVED FOR BINDING

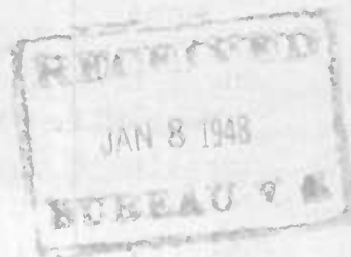
VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ARTIST'S LEDGER

SALE CONTRACT



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

00623

1. PLACE OF DEATH:

County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, institution, or street address where death occurred:
703 Erie Avenue
How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 703 Erie Avenue
(If rural, give LOCATION)
2. (a) If veteran, name war World War II

3. (a) FULL NAME

Romie Claire Burrus, Jr.

3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Divorced
6. (b) Name of husband or wife Divorced
7. Birth date of deceased (mo., day, yr.) Unknown
6. (c) If alive, give age Unknown years
8. AGE: Years 32 Months Days If less than one day hrs. min.

9. Birthplace North Carolina
(Town, county, and state)
10. Usual occupation Radio Technician
11. Industry or business Radio
12. Name Romie C. Burrus
13. Birthplace North Carolina
14. Maiden name Viola Butner
15. Birthplace North Carolina

16. Informant Mrs. Ella Farlow
Address Ashboro, North Carolina
17. Burial-Transit Jan. 18, 1948
(Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)
Cemetery or crematory Rockford Cemetery
Location Rockford, North Carolina

18. Funeral director Wm. Raulen Humphrey
Address Bethesda, Maryland

19. 1/18 19 48 Wm E Jones Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 - January 19 48 at 4:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 19 47 to Jan 18 19 48
and that I last saw him alive on Jan 17 19 48
Immediate cause of death Coronary heart failure
DURATION 64 mo
Due to Rheumatic heart disease
mitral stenosis 24 yrs
Due to Rheumatic fever
Other conditions Pulmonary Infarctus
recurrent 3 mo
(Include pregnancy within 3 months of death)
Major findings of operations None
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Andrew G. Prandoni M. D. or other
Address 3025 Eye St NW Date signed 1-18-48
Washington DC

MARGIN RESERVED FOR BINDING

VS A15, 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 22 1948
RTH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

830W

00624

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MONTGOMERY
City or town CHEVY CHASE, MD
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, street address where death occurred:

6711 Delfield Place

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County MONTGOMERYCity or town CHEVY CHASE
(If outside city or town limits, write RURAL and give nearest town)Street No. 6711 DELFIELD PLACE
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

ANNA SIDNEY CASANGES

3.(b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced W6.(b) Name of husband or wife CONSTANTINE
P. CASANGES 6.(c) If alive, give age years7. Birth date of
deceased (mo., day, yr.) 18648. AGE: Years Months Days If less than one day
87. approximately hrs. min.9. Birthplace CINCINNATI OHIO
(Town, county, and state)10. Usual occupation HOUSE WIFE11. Industry or business NONE12. Name JOHN GAFIE13. Birthplace URBANO, OHIO14. Maiden name ANNIE KELLY15. Birthplace TIMMONSVILLE PA.16. Informant ALEXANDER N. CASANGESAddress 6711 DELFIELD PLACE17. Cremation Date thereof 1/28/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Cedar HillLocation MD18. Funeral director Jas. Saunders SonsAddress 1756 Penn Ave NW19. 1/28/48 Wm E. John
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26, 1948 at 8:30 A.M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
1936 to Jan 26, 1948
and that I last saw him alive on Jan 25, 1948Immediate cause of death Cerebral Hemorrhage DURATION 5 daysDue to Hypertension

Due to

Other conditions Generalized arterio-sclerosis
(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Ernest G. Purse M.D.
M. D. or otherAddress 801 - E. St. NW Date signed Jan 26, 1948
Washington 6, D.C.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 29 1948
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00625

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 months, 11 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 2 months, 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ala. County _____
 City or town Northport
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1209 Main Avenue
 (If rural, give LOCATION)
 2. (a) If veteran, name war WWI & II ✓

3. (a) FULL NAME

CHRISTIAN, Wilbourn Osco

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Lucille Christian
 6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) September 2, 1901

8. AGE: Years 46 Months 4 Days 13 If less than one day _____ hrs. _____ min.

9. Birthplace Ala.
 (Town, county, and state)

10. Usual occupation Marine Corps Retired

11. Industry or business _____

12. Name CHRISTIAN, Thomas
 13. Birthplace Ala.

14. Maiden name CLEMENTS, Carrie dec.
 15. Birthplace Ala.

16. Informant wife: Mrs. Lucille Christian
 Address 1209 Main Avenue, Northport, Ala.

17. burial Date thereof _____ (month) (day) (year)
 (Burial, cremation, or removal. Which?)

Cemetery or crematory _____
 Location Northport, Ala.

18. Funeral director FYSONG FUNERAL HOME BRT.
 Address 1300 N St., N.W., Wash., D.C.
Mary C. Patterson

19. 1-15 1948 Mary C. Patterson Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 January 1948 at 11:45A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 November 1947 to 15 January 1948
 and that I last saw him alive on 15 January 1948

Immediate cause of death Carcinoma lung DURATION 4 months

Due to _____
 Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____

Means of injury stab with Injured at work? _____
 23. SIGNATURE C. H. C. SMITH, Cor. MC USN

M. D. or other _____
 Address USNH Bethesda, Md. Date signed 1-15-48

JAN 19 1948
BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

County... Montgomery
 City or town... Rockville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 191 years
 Hospital, institution, or street address where death occurred:
601 Anderson Avenue
 How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Montgomery
 City or town... Rockville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 601 Anderson Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war... None

3. (a) FULL NAME

- - - - - Sarah Virginia Cochran - - - - -

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife Levi W. Cochran6. (c) If alive, give age 74 years7. Birth date of deceased (mo., day, yr.) December 1st, 1870

8. AGE:

77

Years

77

Months

1

Days

15

If less than one day

- hrs.

- min.

9. Birthplace Hamilton, Virginia

(Town, county, and state)

10. Usual occupation Housewife11. Industry or business NoneFATHER 12. Name Samuel Lewis13. Birthplace VirginiaMOTHER 14. Maiden name Sarah V. Bell15. Birthplace Virginia16. Informant Mr. Levi W. CochranAddress Rockville, Maryland17. Burial Date thereof Jan. 19, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Rockville Union CemeteryLocation Rockville, Maryland18. Funeral director Wm. Hadden HumphreyAddress Rockville, Maryland19. 1/19/48 Ed Shoups
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 16, 1948 at 6:30 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945 to Jan. 16, 1948.and that I last saw him alive on Jan. 16, 1948.

Immediate cause of death

DURATION

Myocardial failureTwo days

Due to

Arteriosclerosis

Due to

Hypertension

Other conditions

Auricular fibrillation2 years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Wm. H. Humphrey M.D.

M. D. or other

Address Rockville, Md. Date signed 1/16/48

RECEIVED

JAN 22 1948

SECRET

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00627

Reg. Dist. No. 223-

1. PLACE OF DEATH:

County Montgomery
 City or town Takoma Park Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Montgomery
 City or town Takoma Park Md.
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 45 Poplar Ave
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

John W. Crawford

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Mary Crawford

7. Birth date of deceased (mo., day, yr.)

July 3, 1863

8. AGE:

84 Years Months Days It less than one day

9. Birthplace

Delaware
(town, county, and state)

10. Usual occupation

Retired

11. Industry or business

12. Name William Crawford13. Birthplace Scotland14. Maiden name Ann Forrest15. Birthplace Scotland16. Informant Mrs Raymond MorganAddress 4800 Guilford Rd. College Park17. Burial Date thereof Jan 12 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Washington Bel18. Funeral director Neal Funeral HomeAddress 4812 Sa Ave NW. DC19. Jan 9 19 48 J.W. Dudley
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9 19 48 at 5:09 pm21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 12 19 47 to January 9 19 48and that I last saw him alive on January 9 19 48

Immediate cause of death

Respiratory FailureDue to Cerebral AccidentDue to Cerebral ArteriosclerosisOther conditions Generalized Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Ante-mortem results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dean H. Harding M.D.Address 112 Carroll St NW Date signed 1-9-48Wash DC

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, and cause of death. The form is mostly blank with some faint markings.

RECEIVED
JAN 12 1948
DEPT. OF HEALTH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County.....Montgomery
 City or town.....Chevy Chase
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Md. County.....Montgomery
 City or town.....Chevy Chase
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 6503 Brennon Lane
 (If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Hattie B. Crow

3. (b) Social Security Number

4. Sex.....Female
 5. Color or race.....White
 6. (a) Single, married, widowed, or divorced.....Widowed

6. (b) Name of husband or wife.....Lawrence Crow

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....Sept. 1, 1870

8. AGE: Years.....76 Months..... Days..... If less than one day..... hrs. min.

9. Birthplace.....Wilmington Del.
 (Town, county, and state)
 10. Usual occupation.....Housewife

11. Industry or business

12. Name.....Alfred Redmile
 13. Birthplace.....England

14. Maiden name.....Minerva Weatherby
 15. Birthplace.....Del.

16. Informant.....Frances Seaton
 Address.....6503 Brennon Lane

17. Burial Date thereof.....Jan. 5, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Arlington Nat.
 Location.....Arlington Va.

18. Funeral director.....Deal Funeral Home
 Address.....4812 Georgia Ave. N. W.

19. 1/7 1948 Thm E Jones
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....Jan 1 1948 at 3:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dec 18 1943, to Jan 1 1948
 and that I last saw him alive on Jan 1 1948

Immediate cause of death.....Myocarditis & Terminal
Heart Failure
Myocarditis & Terminal

Due to.....Myocarditis & Terminal

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

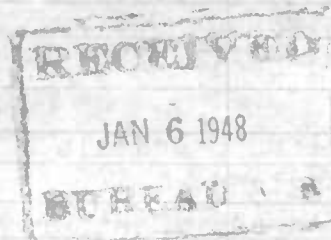
23. SIGNATURE.....John V. Dolan

M. D. or other

Address.....3160 Conn Ave Date signed.....1/1/48

5012

Maple Ridge Rd.



Dr. Logan
31 Oxford St.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

00629

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

County Montgomery
 City or town Rockville, MD.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Rockville, MD. Mont
 City or town Rockville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. none
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3.(a) FULL NAME

Achsah L. Davis

3.(b) Social Security Number

none

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife
 6.(c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) April 20 1855
 8. AGE: Years 92 Months 8 Days 14 If less than one day
 hrs. min.

9. Birthplace Maryland
 (Town, county, and state)
 10. Usual occupation none
 11. Industry or business none
 12. Name Franklin Grooms
 13. Birthplace Maryland
 14. Maiden name Mary Ann Hobbs Davis
 15. Birthplace MD.

16. Informant Mrs. Susie D. Waters
Sandy Spring, MD.
 Address

17. Burial Jan. 5 1948
 (Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)
 Cemetery or crematory Laytonsville, MD.
Montgomery, CO. MD.
 Location

18. Funeral director Roy W. Barber
Laytonsville, MD.
 Address

19. 1-5- 19 48
 (Date rec'd by registrar) EP Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 3 19 48 at 7:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 13, 1947 to January 3, 1948
 and that I last saw him alive on January 2 19 48

Immediate cause of death Cerebral apoplexy DURATION 20 days

Due to arterio-sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. P. Hartley, M.D. M. D. or other

Address Rockville, Md. Date signed 1/5/48

RECEIVED

JAN 7 1948

STANDARD

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00630

1. PLACE OF DEATH: Montgomery
County.....
City or town..... Silver Spring, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? From 11/10/44
Hospital, institution, or street address where death occurred:
Cedarcroft Sanitarium
How long in hospital or institution? From 11/10/44

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore City
City or town..... Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. formerly 1229 E. Preston St.
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME MARGARETHA (ZAPF) DERSCH

3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife John Dersch

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1865

8. AGE: Years 82 Months 11 Days..... If less than one day..... hrs. min.

9. Birthplace..... Baltimore, Balt. City, Md.
(Town, county, and state)

10. Usual occupation..... housewife

11. Industry or business

FATHER 12. Name..... zapf

13. Birthplace..... Germany

MOTHER 14. Maiden name..... Don't know

15. Birthplace..... Germany

16. Informant..... Mrs. Richard C. Null

Address Oaklee Village, Baltimore Md.

Apt. 158

17. Buried Date thereof Jan 13/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Bethelton Cem

Location..... City

18. Funeral director..... Harriet Funeral Home

Address 2008 Orleans St

19. 1-15-48 19.....
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan. 10 - 1948 at 9:50 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 10 - 1944 to Jan 10 - 1948 and that I last saw him alive on Jan 9 - 1948

Immediate cause of death..... DURATION

Cerebral Hemorrhage 2 days

Due to..... Arteriosclerosis & Hypertension ?

Due to.....

Other conditions..... Senile Psychosis

(Include pregnancy within 6 months of death)

Major findings of operations.....

Antopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... W.B. Thibodeau M.D.
M. D. or other

Address..... Cedarcroft Sanitarium
Silver Spring, Md. Date signed 1/10-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00631

Reg. Dist. No. 211

1. PLACE OF DEATH:

County Montgomery
 City or town Friendship Rural P.F.D.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? all life
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Montgomery
 City or town Friendship Rural P.F.D.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(u) If veteran, name war _____

3. (a) FULL NAME

Henry Dorsey (DORSEY)

3. (b) Social Security Number

4. Sex Male 5. Color or race Col 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

1852 Unknown
 8. AGE: Years 95 Months - Days - If less than one day _____ hrs. _____ min.

9. Birthplace

Maryland
 (Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Farmer

FATHER

12. Name Unknown

13. Birthplace Basel Cheever Dorsey

MOTHER

14. Maiden name Howard Co Md

15. Birthplace Howard Co Md

16. Informant Mrs. Paul Derry

Address Monrovia md

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Jan 14 - 1948
 (month) (day) (year)

Cemetery or crematory Friendship md

Location Claggettville md

18. Funeral director Robt W. Barber

Address Claggettville md

19. John 18 48 Della W Bartlett
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11, 1948 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 6, 1946 to January 11, 1948

and that I last saw him live on January 10, 1948

Immediate cause of death arteriosclerotic cardiovascular disease

vascular disease

DURATION 15 yrs.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE James P. Kerr M.D.

Address Dundee, Md. M. D. or other _____

Date signed 1/14/48

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

JAN 17 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13/a

00632

Reg. Dist. No. 716

1. PLACE OF DEATH

County Montgomery
 City or town Cherry Chase, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 31 years
 Hospital, institution, or street address where death occurred:
104 Chevy Chase Drive
 How long in hospital or institution? ----

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Montgomery
 City or town Cherry Chase
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 104 Chevy Chase Drive
 (If rural, give LOCATION)
 2.(a) If veteran, name war N6

3. (a) FULL NAME

Sarah Alden Dorsey

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Husband: Vernon M. Dorsey

7. Birth date of deceased (mo., day, yr.) Nov. 10 1871 6. (c) If alive, give age 78 years

8. AGE: Years 76 Months 76 Days 2 8 hrs. 8 min. 8

9. Birthplace Washington, D.C.
 (Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

James Madison Alden

12. Name Mass.

13. Birthplace Mass.

14. Maiden name Charlotte Bounce

15. Birthplace Marlboro, Md.

16. Informant Vernon M. Dorsey

Address 11 East. Underwood, Cherry Chase, Md.

17. Burial Date thereof Jan. 20 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Glenwood Cemetery

Location Washington, D. C.

18. Funeral director Wm. Ransom Pamphrey

Address Bethesda, Maryland

19. Jan 19 1948 Wm E Jones

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 18 1948 at 12:30 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Mar 13 1946 to Jan 18 1948

and that I last saw him alive on Jan 18 1948

Immediate cause of death Acute Pericarditis DURATION

Due to Hypertension

Due to Arteriosclerosis

Due to Chronic Bronchitis

Other conditions Edema

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joseph B. Bateman, M.D.

Address 3010 Wisconsin Ave. N.W.

Date signed Jan 18 1948

RECEIVED
JAN 22 1948
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1310

00633

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

County Montgomery
 City or town Avery Rural Rockville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montg.
 City or town Avery
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Lucinda Clemons

3. (b) Social Security Number

Dow

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female C widowed

6. (b) Name of husband or wife

Henson Dow

7. Birth date of deceased (mo., day, yr.)

Sept 12, 1869

6. (c) If alive, give age _____ years

8. AGE:

78

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Montgomery
(Town, county, and state)

10. Usual occupation

Housekeeper

11. Industry or business

FATHER

12. Name

Walt Clemons

13. Birthplace

Montgomery

14. Maiden name

Mary Bacon

15. Birthplace

Montgomery

16. Informant

Mollie King (Daughter)

Address

Rockville, Md. 1770 #

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

Jan. 14, 1948
(month) (day) (year)

Cemetery or crematory

Norbeck

Location

Norbeck, Md.

18. Funeral director

Robert L. Sewell

Address

246-N. Wash. St. Rockville Md.19. 1-14 19. 48
(Date rec'd by registrar)SP Shoup
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 12, 48 at 1:00 PM

21. I CERTIFY that death occurred on the data above stated: that I attended deceased from

July 15, 1935 to January 12, 1948and that I last saw her alive on January 10, 1948Immediate cause of death Occlusion DURATIONCerebral artery middle 4 DaysDue to ArteriosclerosisDue to Cerebral + CoronaryOther conditions Chronic Nephritiswithout Edema
(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE Robert L. Sewell, M.D. M. D. or otherAddress Norbeck, Md. Date signed Jan 12, 48

RECEIVED

JAN 15 1948

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: Montgomery
County Rural - near Rockville
City or town 5 1/2 month
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Wanerley Sanitarium
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 5 1/2 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County Washington
City or town 5039 Lowell St. N.W.
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME

Sarah B. Floyd Dyer

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife James W.
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug. 9 1870
8. AGE: Years 77 Months 4 Days 6 If less than one day hrs. min.

9. Birthplace Wash. D.C.
(Town, county, and state)

10. Usual occupation home

11. Industry or business

12. Name Charles M. Floyd

13. Birthplace New York

14. Maiden name Deha

15. Birthplace Mass.

16. Informant Chas. F. Dyer (son)

Address 1530 16th St. N.W.

17. (Burial, cremation, or removal. Which?) Date thereof 1-22-48
(month) (day) (year)

Cemetery or crematory mt. Olivet

Location Wash. D.C.

18. Funeral director S. H. Hines Co.

Address 2901-14th St. N.W.

19. 1/19 48 Wm E Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 19-1948 at 6:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 15 1947 to Jan. 19-1948
and that I last saw her alive on Jan. 19th 1948

Immediate cause of death Chronic myocardial insufficiency. DURATION 1 year

Due to Degeneration of cardiac muscle. Unknown

Due to Carcinoma of the uterus. Unknown
(Include pregnancy within 8 months of death)

Major findings of operations None

Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of None

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) None

Means of injury Wheelchair Injured at work? None

23. SIGNATURE Wheeler Duff M.D. or other None

Address Bethesda, Md. Date signed Jan. 19-1948

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. We correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 22 1948

ET 456

RECEIVED

JAN 27 1948

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00636

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 27 days
 Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland
 How long in hospital or institution? 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State La. County _____
 City or town Westwego
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 223 Sale Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

EPKIN, Sherryl Winona

3. (b) Social Security Number

4. Sex female 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____ 6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 7 December 1947

8. AGE: Years _____ Months _____ Days 27 If less than one day _____ hrs. _____ min.

9. Birthplace Bethesda, Maryland
 (Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name Norman D. Epkin

13. Birthplace Mississippi

14. Maiden name PETTIES, Annie Merle

15. Birthplace La.

16. Informant Fa: Cpl. Norman D. Epkin, USMC
Marine Barracks, Wash., D.C.

17. burial Date thereof _____
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Westwego Cemetery

Location Westwego, Louisiana

18. Funeral director Malvan and Schey

Address 424 R St., NW, Wash., D.C.

19. 1-4- 48 Mary C. Patterson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 January 19 48 at _____ M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 December 19 47 to 3 January 19 48

and that I last saw her alive on 3 January 19 48

Immediate cause of death malnutrition DURATION 27 da

Due to atrophy of duodenum 27 da

Due to atrophy of lower ileum 27 da

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations atrophy of duodenum
ileum Date of op. 12-12-47

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE PAUL PETERSON, Capt. MC USN
 M. D. or other _____

Address USNH Bethesda, Md. Date signed 1-3-48

MARGIN RESERVED FOR BINDING

9.45.15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 10 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

00637

223

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Montgomery
 City or town Takoma Park, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 days
 Hospital, institution, or street address where death occurred:
Washington Sanitarium and Hospital
 How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Montgomery
 City or town Silver Spring, Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1914 Grace Church Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Dr. Warren D. Fales -

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Dr. Ella R. Fales
 7. Birth date of deceased (mo., day, yr.) April-22, 1868 6. (c) If alive, give age years
 8. AGE: Years 79 Months 9 Days 4 If less than one day hrs. min.

9. Birthplace Chenoa, Illinois
 (Town, county, and state)
 10. Usual occupation physician (Retired)
 11. Industry or business

FATHER 12. Name Warren M. Fales
 13. Birthplace Dedham, Mass.
 MOTHER 14. Maiden name Charlotte Nichols
 15. Birthplace Reading, Mass.
 16. Informant patient's Hospital chart
 Address

17. BURIAL Date thereof JAN 21-1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory ARLINGTON NATIONAL
ARLINGTON CO-VIRGINIA
 Location
 18. Funeral director Warner E. Humphrey, Inc.
 Address SILVER SPRING, MD.
 19. Jan. 19 1948 J. William Dettl
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18 1948
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 9 1948 to Jan 18 1948
 and that I last saw him alive on Jan 18 1948
 Immediate cause of death Confusional Heart failure
 DURATION acute
 Due to Arteriosclerotic Heart from
Myocardial and Congestive
Heart failure
 Due to Arteriosclerotic Hypertrophy
Myocardial Arteriosclerosis
 (Include pregnancy within 3 months of death)
 Major findings of operations Date of op.
 Autopsy results As above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE Dr. J. W. Dettl M. D. or other
Takoma Park, Md Date signed 1-18-48

RECEIVED

JAN 22 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00638 714

1. PLACE OF DEATH:

County MontgomeryCity or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

How long in above place of death?

Street address where death occurred:
750 Thayer Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)Street No. 750 Thayer Ave.
(If rural, give LOCATION)2.(a) ☒ If veteran, name war.

3. (a) FULL NAME

Floyd Jefferson Farber

3. (b) Social Security Number

4. Sex male5. Color or race white6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Florence Victoria

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Jan. 6th. 18848. AGE: Years 64 Months 0 Days 5 If less than one day
..... hrs. min.9. Birthplace Iowa
(Town, county, and state)10. Usual occupation Retired Lt. U. S. Navy

11. Industry or business

12. Name Thomas Jefferson Farber13. Birthplace Lucas, Iowa.14. Maiden name Elsa Bager15. Birthplace Virginia18. Informant Mrs. Florence V. FarberAddress 750 Thayer Ave. Silver Spring.17. Burial Date thereof Jan. 14th. 48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery Arlington NationalLocation Arlington Co. Virginia.18. Funeral director Wm. E. HumphreyAddress Silver Spring, Md.19. Date rec'd by registrar Jan. 13 1948 Josephine Schaeffle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11 1948 at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 2 1939 to Oct. 1947and that I last saw him alive on Oct 2 1947

Immediate cause of death

Acute cardiac dilatation DURATION 5 mi.Due to Pneumonia Lobar 1 monthDue to Generalized Arteriosclerosis 10 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W B Wardrop Jr. M. D. or otherAddress 943 Bayfield St. Date signed 1/11/48
Silver Spring, Md.

RECEIVED
JAN 15 1948
ST. PAUL

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 716

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 18 days

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)Street No. 619 E Thornapple Street,

(If rural, give LOCATION)

2. (a) If veteran, name war None

3. (a) FULL NAME

Carrie E. Faris

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Robert Lee Faris7. Birth date of deceased (mo., day, yr.) March 22, 1870

6. (c) If alive, give age _____ years

8. AGE: Years Months Days If less than one day
77 77 10 8 _____ hrs. _____ min.9. Birthplace Frederick County, Maryland
(Town, county, and state)10. Usual occupation Housewife11. Industry or business None12. Name William Hellen13. Birthplace Calvert County, Maryland14. Maiden name Sarah Rawlings Mills15. Birthplace Calvert County, Maryland16. Informant Robert L. Faris - SonAddress Chevy Chase, Maryland17. Burial Date thereof Jan. 10, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Rock Creek CemeteryLocation Washington, D. C.18. Funeral director Wm E. JonesAddress Bethesda, Maryland19. 1/9 48 Wm E. Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8, 19 48, at 6:00A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 8 19 47 to Jan 8 19 48and that I last saw him alive on Jan 5 19 48

Immediate cause of death

Congestive heart failure 2 daysmyocardial infarction 7 daysDue to myocardial infarction 1 minDue to Hypertension, general yearsarterio-sclerosis 3 yearsOther conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Gilbert B. Rode M.D.Address 3900 Military Rd. Date signed 1/8/48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 10 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

Flint

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County Montgomery
City or town Pahome Park, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

809 Maple Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Montgomery County Cherry Chase

City or town 107 Oxford St.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 107 Oxford St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

ELLA L. FLINT

3. (b) Social Security Number

None

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife Wm. F. Flint

6.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

May 14, 1886

8. AGE:

Years

91

Months

7

Days

23

If less than one day

hrs. min.

9. Birthplace

Luna, Mo.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Same

FATHER

12. Name

Wm. F. Flint

13. Birthplace

Calum.

MOTHER

14. Maiden name

Flint

15. Birthplace

Calum.

16. Informant

Mr. Carl S. Flint

Address

107 Oxford St., Cherry Chase, Md

17.

(Burial, cremation, or removal. Which?)

Date thereof

Jan. 10, 1948.
(month) (day) (year)

Cemetery or crematory

Location

Medford, Massachusetts

18. Funeral director

John Staller

Address

254 Carroll St., T. H. Phelps Park, D. C.

19.

(Date rec'd by registrar)

Jan. 8, 1948

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-7-48 19 at 3:59 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-3-48 19 to 1-7-48 19

and that I last saw him alive on 1-7-48 19

Immediate cause of death

Acute Cardiac Failure

DURATION

Due to

Pneumonia Bronchopneumonia

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dean H. Harding, M.D.

M. D. or other

Address

113 Carroll St NW

Date signed 1-7-48

Wash DC

DEPARTMENT OF THE ARMY

WASHINGTON, D. C. 20315

OFFICE OF THE ADJUTANT GENERAL

1. NAME OF THE OFFICER OR PERSON TO WHOM THIS ORDER IS ISSUED

2. GRADE OR POSITION OF THE OFFICER OR PERSON TO WHOM THIS ORDER IS ISSUED

3. NAME OF THE OFFICER OR PERSON ISSUING THIS ORDER

4. GRADE OR POSITION OF THE OFFICER OR PERSON ISSUING THIS ORDER

5. DATE OF ISSUANCE OF THIS ORDER

6. PLACE OF ISSUANCE OF THIS ORDER

7. SUBJECT OF THIS ORDER

8. ACTION REQUIRED BY THE OFFICER OR PERSON TO WHOM THIS ORDER IS ISSUED

9. ACTION REQUIRED BY THE OFFICER OR PERSON ISSUING THIS ORDER

10. ACTION REQUIRED BY THE OFFICER OR PERSON TO WHOM THIS ORDER IS ISSUED

11. ACTION REQUIRED BY THE OFFICER OR PERSON ISSUING THIS ORDER

12. ACTION REQUIRED BY THE OFFICER OR PERSON TO WHOM THIS ORDER IS ISSUED

13. ACTION REQUIRED BY THE OFFICER OR PERSON ISSUING THIS ORDER

14. ACTION REQUIRED BY THE OFFICER OR PERSON TO WHOM THIS ORDER IS ISSUED

15. ACTION REQUIRED BY THE OFFICER OR PERSON ISSUING THIS ORDER

16. ACTION REQUIRED BY THE OFFICER OR PERSON TO WHOM THIS ORDER IS ISSUED

17. ACTION REQUIRED BY THE OFFICER OR PERSON ISSUING THIS ORDER

18. ACTION REQUIRED BY THE OFFICER OR PERSON TO WHOM THIS ORDER IS ISSUED

19. ACTION REQUIRED BY THE OFFICER OR PERSON ISSUING THIS ORDER

20. ACTION REQUIRED BY THE OFFICER OR PERSON TO WHOM THIS ORDER IS ISSUED

21. ACTION REQUIRED BY THE OFFICER OR PERSON ISSUING THIS ORDER

22. ACTION REQUIRED BY THE OFFICER OR PERSON TO WHOM THIS ORDER IS ISSUED

RECEIVED

JAN 10 1948

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00641

Reg. Diat. No.

2

1. PLACE OF DEATH:

County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Sudden death
Hospital, institution, or street address where death occurred:
Little Falls Br. & Mass Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 424 Dorset Avenue
(If rural, give LOCATION)
No
2.(a) If veteran, name war

3. (a) FULL NAME

PAUL HART FRANCIS

3. (b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Married

6.(b) Name of husband or wife Helen Gerst Francis

7. Birth date of deceased (mo., day, yr.) December 28, 1891
6.(c) If alive, give age ? years

8. AGE: Years Months Days If less than one day
57 0 14 hrs. min.

9. Birthplace Cranston, R. I.
(Town, county, and state)

10. Usual occupation Civil Engineer

11. Industry or business Navy Dept.

FATHER 12. Name Henry N. Francis

13. Birthplace Connecticut

MOTHER 14. Maiden name Emily Pettis

15. Birthplace Connecticut

16. Informant Mrs. Helen Gerst Francis
Address 424 Dorset Ave., Chevy Chase, Md.

17. Cremation Date thereof Feb. 29, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill Crematory

Location Washington, D.C.

18. Funeral director Wm. J. Hansen

Address Bethesda, Maryland

19. 2/29 48 Wm E Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Unknown. Probable Jan 12, 1948 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam to 19 and that I last saw him alive on case 19

Immediate cause of death Exposure (accidental)
found in creek
Due to 2-28-48

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accidental Date of about 1-12-48
Where did injury occur? Bethesda Monty md
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

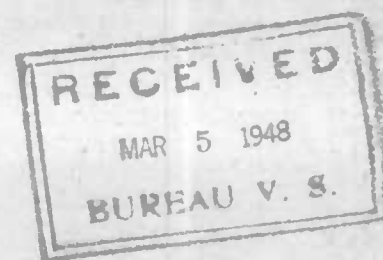
Means of injury Injured at work?

23. SIGNATURE Frank J. Bruchart M.D.
Dep. Med. Exam M. D. or other
Address Washington md Date signed 2-28-48

MARGIN RESERVED FOR BINDING

VS A15 9.45:15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170c

00642

Reg. Dist. No.

216

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Montgomery
 City or town R.F.D. #3, Bethesda 14, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 yrs.
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town R.F.D. #3, Bethesda 14, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. River Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war No

3.(a) FULL NAME

MARCUS EDGAR FRAZIER

3.(b) Social Security Number

579-12-9069

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Mary Jane
 7. Birth date of deceased (mo., day, yr.) 1884 November (day unknown) 6.(c) If alive, give age _____ years
 8. AGE: Years 63 Months --- Days --- If less than one day _____ hrs. _____ min.

9. Birthplace Virginia
 (Town, county, and state)
 10. Usual occupation Laborer
 11. Industry or business None
 12. Name James Frazier
 13. Birthplace Virginia
 14. Maiden name Louise
 15. Birthplace Virginia

16. Informant Mr. Raymond H. Frazier
 Address River Road, R.F.D. #3 Bethesda
 17. Burial
 (Burial, cremation, or removal. Which?) Date thereof _____ (month) (day) (year)
 Cemetery or crematory Boston Cemetery
 Location Boston, Virginia
 18. Funeral director Wm. E. Jones
 Address 7557 Wisconsin Ave. Bethesda 14

19. Jan 24 19 48
 Date rec'd by registrar _____ Registrar Wm E Jones

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 21st 19 48 at 5:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____
 and that I last saw him _____ alive on _____ 19 _____

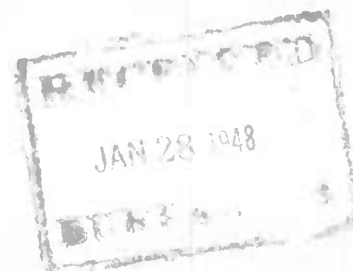
Immediate cause of death Dep. Med. Exam. Case DURATION Sudden
Death
 Due to Cerebral hemorrhage
fracture of skull 1-4-48
 Other conditions Found dead in home
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide accidental Date of 1-4-48
 Where did injury occur? Bethesda Montgomery Md
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) Highway
 Means of injury Struck by auto Injured at work? no

23. SIGNATURE Frank J. Brochert M. D. or other
Dep. Med. Exam.
 Address Gaithersburg, Md. Date signed 1/21/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00643

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 1/2 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Va. County _____
 City or town Arlington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1319 N. Harrison Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war WWI

3. (a) FULL NAME

GALVIN, Richard Joseph

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced single
 6.(b) Name of husband or wife _____
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) September 24, 1890
 8. AGE: Years 57 Months 3 Days 6 It less than one day _____ hrs. _____ min.

9. Birthplace Conn.
 (Town, county, and state)
 10. Usual occupation Retired Army Personnel
 11. Industry or business _____
 12. Name GALVIN, John
 13. Birthplace Ill.
 14. Maiden name ALLEN, Rose
 15. Birthplace Ill.

16. Informant Sister, Mrs. Loretta Stanton
 Address 432 Algonquin Avenue, Detroit, 14, Mich.
 17. burial Date thereof 1-23-48
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Arlington National
Arlington, Va.
 Location _____

18. Funeral director W. W. CHAMBERS
 Address Georgetown, D.C.
Mary C. Patterson
Mary C. Patterson
 19. 1-21- 19 48
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 January 19 48 at 6:40 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
16 January 19 48, to 21 Jan 19 48
 and that I last saw him alive on 21 January 19 48
 Immediate cause of death _____
Coronary Thrombosis
 Due to Coronary Heart Disease,
Arteriosclerotic
 Due to _____
 Other conditions Status Asthmaticus
Hypertensive Heart Disease
 (Include pregnancy within 3 months of death)
 DURATION 12 hrs.
indef.
10 days

Major findings of operations _____ Date of op. _____
 Autopsy results confirmed above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

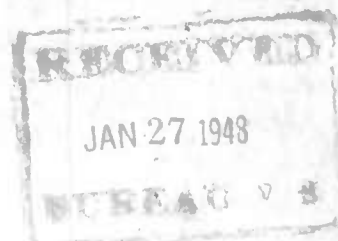
22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE H. R. COOPER, Lt. MC USN
H. R. COOPER, Lt. MC USN
 Address USNH Bethesda, Md. Date signed 1-21-48
 M. D. or other _____

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age especially important. Physicians: please write the causes of death clearly and legibly



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95c

00644

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County *Montgomery*City or town *Takoma Park*
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *5 yrs*

Hospital, institution, or street address where death occurred:

810 Greenwood Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Montgomery*City or town *Takoma Park*
(If outside city or town limits, write RURAL and give nearest town)Street No. *810 Greenwood Ave*

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Dora Frances Gentzel

3. (b) Social Security Number

4. Sex *Female* 5. Color or race *W* 6. (a) Single, married, widowed, or divorced *Widowed*6. (b) Name of husband or wife *Ernest Gentzel*7. Birth date of deceased (mo., day, yr.) *Apr 9 1858* 6. (c) If alive, give age _____ years8. AGE: Years *89* Months *7* Days *26* It less than one day _____ hrs. _____ min.9. Birthplace *Germantown*
(Town, county, and state)10. Usual occupation *Housework*

11. Industry or business

12. Name *Unknown*

13. Birthplace

14. Maiden name *Unknown*

15. Birthplace

16. Informant *Dorothy Alvaros*Address *810 Greenwood Ave. Takoma Park Md*17. *Burial* Date thereof *Jan 8, 1948*
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory *Palmyra Memorial Cem.*Location *Jersey City, New Jersey*18. Funeral director *Arthur J. Walters*Address *234 Carroll St. Takoma Park, D.C.*19. *Jan 6 1948* (Date rec'd by registrar) Registrar *Almon Dool*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Jan 5 1948* at *11:30 A.M.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Def med Exam case*

and that I last saw him alive on _____ 19____

Immediate cause of death _____ 19____

Due to _____

Due to _____

Other conditions _____

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

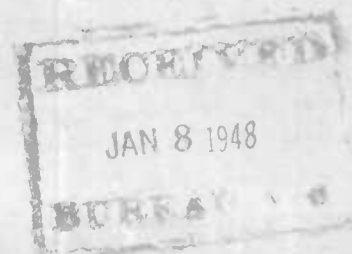
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE *Frank J. Bronckart M.D.*Address *Yakima Md* Date signed *1-5-48*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

00645

CERTIFICATE OF DEATH

Reg. Dist. No. 261

1. PLACE OF DEATH:

County Montgomery
 City or town Rural Clarksburg, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Ten years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Rural Clarksburg, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name War _____

3. (a) FULL NAME

Crimie V Gray

3. (b) Social Security Number

4. Sex Female 5. Color or race col 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife George E Gray
 7. Birth date of deceased (mo., day, yr.) June 29 - 1883 - 6.(c) If alive, give age 73 years
 8. AGE: Years 62 Months 6 Days 9 If less than one day _____ hrs. _____ min.

9. Birthplace Highland CO Va
(Town, county, and state)10. Usual occupation Domestic11. Industry or business Home

MOTHER FATHER
 12. Name George Turner
 13. Birthplace Slayton Va
 14. Maiden name Unknown
 15. Birthplace Unknown

16. Informant George E Gray
 Address Clarksburg, Md

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Jan 10 1948
 (month) (day) (year)

Cemetery or crematory Pleasant Grove, Md
 Location Durham, Md

18. Funeral director Ref W Barber
 Address Laurensville, Md

19. Jan 10 1948 Della D Burdett
 Date rec'd by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7, 1948 at 1:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15, 1945 to January 7, 1948
 and that I last saw him alive on December 15, 1947

Immediate cause of death arteriosclerotic cardiac
vascular disease DURATION 10 years

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE James P. Kerr, M.D. M. D. or other _____Address Laurensville, Md. Date signed 1/7/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

00646

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montgomery
 City or town Colesville - Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

R. F. D. 1 Silver Spring, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Colesville
 (If outside city or town limits, write RURAL and give nearest town)

Street No. R. F. D. 1 Silver Spring
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Frederick Augustus GrimesGrimes.

3. (b) Social Security Number

214-03-8874

4. Sex <u>male</u>	5. Color or race <u>white</u>	6. (a) Single, married, widowed, or divorced <u>married</u>
B. (b) Name of husband or wife <u>Beulah Leizear</u>		
7. Birth date of deceased (mo., day, yr.) <u>Mar. 12th. 1885</u>		
8. AGE: Years <u>62</u>	Months <u>10</u>	Days <u>6</u>
If less than one day hrs. min.		

6. (c) If alive, give age..... years

9. Birthplace Maryland
 (Town, county, and state)

10. Usual occupation Night Watchman

11. Industry or business Wash. Sub. San. Com.

12. Name James B. Grimes

13. Birthplace Maryland

14. Maiden name Louise C. Gover

15. Birthplace Maryland

16. Informant Mrs. Beulah L. Grimes
 Address Colesville, Md.

17. Burial Date thereof 1/20, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or place of interment Colesville Church

Location Colesville, Montg. Co. Md.

18. Funeral director Warner E. Humphrey

Address Silver Spring, Md.

19. Jan 20 19 48 Josephine Schaeffer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 18, 19 48 at M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
January 1 19 46 to January 18 19 48.
 and that I last saw him alive on January 12 19 48

Immediate cause of death Coronary Occlusion

DURATION

30 minutes

Due to Chronic Myocarditis and
Hypertension. 2 years.

Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Josephine Schaeffer M. D. or other
 Address Sandy Spring, Md. Date signed 1/19/48

RECEIVED

RECEIVED

RECEIVED
JAN 23 1948
FIVE

Evidence for the change of
age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00647

FILM No. G 114 FEB 20 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery
City or town Rural Ashton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County MONTGOMERY
City or town RURAL - ASHTON
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2 mi - East
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

WILLIE ANN HALL

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Col.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Richard W. Hall Sr.

6. (c) If alive, give age 77 years

7. Birth date of

deceased (mo., day, yr.)

Sept. 22 - 1868

8. AGE:

79

Year

Months

Days

If less than one day

hr.

min.

9. Birthplace

Lynchburg, Va.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

John Henry Dorsey

13. Birthplace

MOTHER

14. Maiden name

Emley Dorsey

15. Birthplace

16. Informant

Address

Richard W. Hall
Rockville, F.D. #3 Md.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

Jan 21 1948
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Jan 21

(Date rec'd by registrar)

19 48

Gertrude B. Law

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

18 January 48 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7 Jan 48 to 18 Jan 48
and that I last saw him ex alive on 16 Jan 48

Immediate cause of death

Congestive Heart Failure

DURATION

1 wk.

Due to

Arteriosclerotic Heart

Disease

and Chronic Nephritis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury

Injured at work?

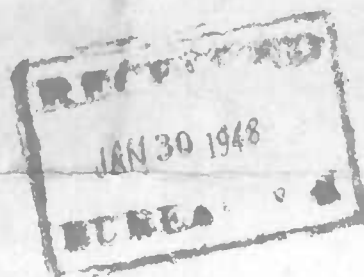
23. SIGNATURE

Charles H. Ligon MD
Sandy Spring Md
Address Date signed 1/18/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County... Montgomery
 City or town... Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 44 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 44 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... D.C. County...
 City or town... Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 937 K St., N.W.
 (If rural, give LOCATION)
 2(a) If veteran, name war... WWI

3. (a) FULL NAME

HALLENBACK, George James

3. (b) Social Security Number

4. Sex... male
 5. Color or race... W-US
 6. (a) Single, married, widowed, or divorced... divorced

6. (b) Name of husband or wife...
 6. (c) If alive, give age... years
 7. Birth date of deceased (mo., day, yr.)... October 1, 1891

8. AGE: Years... 56 Months... 3 Days... 22
 If less than one day... hrs. ... min.

9. Birthplace... N.Y.
 (Town, county, and state)

10. Usual occupation... unknown

11. Industry or business

FATHER 12. Name... Hallenback, Dave dec.

13. Birthplace... N.Y.

MOTHER 14. Maiden name... HEALEY, Harriett dec.

15. Birthplace... N.Y.

16. Informant... sister: Mrs. Frank Bradley

Address... 15 Grant Avenue, Albany, N.Y.

17. burial Date thereof... 1-27-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Arlington National

Location... Arlington, Va.

18. Funeral director... W. W. CHAMBERS & C. D.

Address... Georgetown, D.C.

19. 1-26 48 Mary C. Patterson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... January 23 19 48 at 7:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dec. 10 19 47 to Jan 23 19 48
 and that I last saw him alive on 23 January 19 48

Immediate cause of death... Cerebral Thrombosis DURATION... 21 hrs.

Due to... Generalized Arteriosclerosis yrs.

Due to...

Other conditions... Bronchopneumonia ? days

Ulcer Duodenum ? yrs.
 (Include pregnancy within 3 months of death)

Major findings of operations... Ulcer duodenum

Date of op.

Autopsy results... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury... Injured at work?

23. SIGNATURE... R. N. SHELLEY, CDR MC USN M. D. or other

Address... USNH Bethesda, Md. Date signed... 1-26-48

RECEIVED

JAN 27 1948

STANDARD

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? since 1-14-48
Hospital, institution, or street address where death occurred: Suburban Hosp
8600 Old Georgetown Rd. Bethesda MdHow long in hospital or institution? since 1-14-482. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)State Maryland County _____
City or town Kensington Md
(If outside city or town limits, write RURAL and give nearest town)Street No. 27 Lawrence Ave
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mrs Amy Harwood

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

✓6. (b) Name of husband or wife Fred Harwood

7. Birth date of

deceased (mo., day, yr.) March 25 1868

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

79109

hrs.

min.

9. Birthplace Binghamton N.Y.
(Town, county, and state)10. Usual occupation music teacher+housewife

11. Industry or business

FATHER

12. Name

Chas C Whitney

MOTHER

13. Birthplace

Big Flats N.Y.

14. Maiden name

Jennie B Cleaves

15. Birthplace

Millport N.York16. Informant Mrs Mary BarnesAddress 27 Lawrence Ave - Kensington Md17. Cremation
(Burial, cremation, or removal, Which?)Date thereof 1/26/48
(month) (day) (year)Cemetery or crematory Linn CemeteryLocation Wash. D.C.18. Funeral director Harold L. SlyerAddress 1009 H-Street N.W. + Washington DC19. 1/24/48
(Date rec'd by registrar)Wm E Jones
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 Jan 1948 at 9 A 3021. I CERTIFY that death occurred on the date above stated; that I attended deceased from
10 December 1947 to 24 Jan 1948
and that I last saw her alive on 23 Jan 1948

Immediate cause of death

Cardiomyopathy of respiration
with pulmonary edema

DURATION

2 1/2 years

Due to _____

Due to _____

Other conditions

Atherosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

S. T. Hamble, M.D.

M. D. or other

Address 1843 Newton St. N.W. Date signed 24 Jan 48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The doctor's age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

00650

2/18

1. PLACE OF DEATH: Montgomery

County..... Boyds Md. Rural

City or town..... (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Montgomery

City or town..... Boyds MD Rural
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION) No

2.(a) If veteran, name war.....

3. (a) FULL NAME

Vilda M. Hawkins

3. (b) Social Security Number

No

4. Sex

Female

5. Color or race

Col

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

George O Hawkins

7. Birth date of deceased (mo., day, yr.)

Feb. 8 1882

6. (c) If alive, give age..... years

67

8. AGE:

Years

65

Months

11

Days

23

If less than one day

hrs.

min.

9. Birthplace..... Maryland

(Town, county, and state)
none

10. Usual occupation.....

11. Industry or business

none

MOTHER

12. Name

Charles Brown

13. Birthplace

Maryland

14. Maiden name

Mary Duffin

15. Birthplace

Maryland

16. Informant

George O. Hawkins

Address

Boyds MD.

17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof.....

Feb. 3 1948

(month) (day) (year)

Cemetery or crematory.....

St. Marks

Location

Boyds MD.

Roy W. Barber

18. Funeral director

Address

Laytonsville MD.

19.

(Date rec'd by registrar)

19

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan 31 1948 at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 14 1947 to Jan 30 1948

and that I last saw h..... alive on Jan 30 1948

Immediate cause of death.....

Hemiplegia left side

DURATION

Due to.....

Hemorrhage of brain

Due to.....

Other conditions.....

Hypertensive Compensatory

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Date signed.....

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FEB 5 '48
U. S. DEPT. OF JUSTICE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

00651

214

CERTIFICATE OF DEATH

Reg. Dist. No. _____

1. PLACE OF DEATH:

County MontgomeryCity or town Kensington

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: _____

Stay in hospital or inst. (yrs., or mos., or days) _____

Stay in this community (yrs., or mos., or days) _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County MontgomeryCity or town Kensington Ward No. _____

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 27 W. Washington St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR _____

3. (a) FULL NAME

Isaac Grant Haycraft

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6 (b) Name of husband or wife Daisy S. Haycraft

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) June 1, 18658. AGE: Years 82 Months 7 Days 27 If less than one day _____ hrs. _____ min.9. Birthplace Madelia Minn. (Town, county, and state)10. Usual occupation Real Estate Broker

11. Industry or business

12. Name Isaac Haycraft 13. Birthplace Kentucky14. Maiden name Sarah P. Jolly 15. Birthplace Kentucky16. Informant Charles I. HaycraftAddress 4719 N. 16th. St. Arlington Va.17. Burial Date thereof Jan 30, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory GlenwoodLocation Washington D. C.16. Funeral director Deal Funeral HomeAddress 4812 Georgia Ave. N. W. Wash. D. C.19. Jan 29 1948 Josephine Schaeffer Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28 1948, at 3:55 P.

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 24 1948, to Jan 28 1948and that I last saw him alive on Jan 28 1948Immediate cause of death Cardiac Failure DURATION 4 daysDue to ArteriosclerosisHeart Disease

Due to _____

Other conditions Generalized arteriosclerosis

(Include pregnancy within 8 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

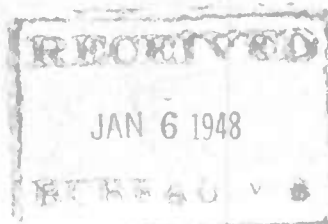
23. SIGNATURE Marion Bauschard M.D. M. D. or other9601 Sutton PlaceAddress Silver Spring, Md. Date signed 1-28-48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

636

00653

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Potomac
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Week

Hospital, institution, or street address where death occurred:

Pine View Rest HomeHow long in hospital or institution? Week

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)Street No. 4 Aspen Street

(If rural, give LOCATION)

None

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Annie Holland

3. (b) Social Security Number

None4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife William Holland..... 6.(c) If alive, give age dec years7. Birth date of deceased (mo., day, yr.) February 28, 18658. AGE: Years 82 Months 82 Days 10 If less than one day 14 hrs. min.9. Birthplace England
(Town, county, and state)10. Usual occupation Housewife11. Industry or business NoneFATHER 12. Name Unknown Hopkins13. Birthplace EnglandMOTHER 14. Maiden name Unknown15. Birthplace England16. Informant Mrs. Ruth H. Toomey (daughter)Address Chevy Chase, Maryland17. Burial-Transit Burial-Transit Date thereof Jan. 17, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Lake View CemeteryLocation Seattle, Washington18. Funeral director WM. Landon HumphreyAddress Bethesda, Maryland19. Jan. 13th, 1948
(Date rec'd by registrar)Mrs E Jones
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 12th, 1948, 11:50A21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 47 to Jan 48 and that I last saw him alive on Jan 11, 1948Immediate cause of death Cerebral Embolism

DURATION

18 hrsDue to Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. L. L. Conner M. D. or otherAddress 8016 Hampton Rd Date signed 1/13/48

RECEIVED

JAN 20 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County Montgomery
 City or town Takoma Park, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 1/2 days
 Hospital, institution, or street address where death occurred:
Washington Sanitarium or Hospital
 How long in hospital or institution? 2 1/2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1508 Ballard St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Hooe, Mr. Robert Emmett

3. (b) Social Security Number

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed
 6. (b) Name of husband or wife deceased
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) Jan. 23, 1861
 8. AGE: Years 86 Months 11 Days 19 If less than one day
 hrs. min.

9. Birthplace Virginia
 (Town, county, and state)
 10. Usual occupation Fred Merchant
 11. Industry or business Own business
 FATHER 12. Name John Hooe,
 13. Birthplace Virginia
 MOTHER 14. Maiden name Culp,
 15. Birthplace Virginia

16. Informant Wash. San. & Hosp. Records
and Margaret Ferguson
 Address Takoma Park, Maryland
 17. Burial Date thereof Jan. 13, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Warrenton
 Location Warrenton, Va.
 18. Funeral director W. H. Chambers Co.
 Address 1400 - Chapin St. N.W.
 19. 1-10 1948
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 10 1948 at 1:40 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
JAN 6 1948 to JAN 10 1948
 and that I last saw him alive on JAN. 9 1948
 Immediate cause of death Bronchial Pneumonia Terminal
Cardiac Heart failure
 Due to.....
 Due to.....
 Other conditions Chronic sclerotic Heart
disorder
 (Include pregnancy within 3 months of death)
 DURATION
4 days
1 week
5 yrs.

Major findings of operations.....
 Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE James P. Richard M.D.
 M. D. or other
 Address 717, Alhambra Dr. N.W. Date signed 1-10-48

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JAN 14 1948
BUREAU 78

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

00655

213

1. PLACE OF DEATH:

County Montgomery

City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:
301 Great Falls Road,

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 301 Great Falls Road
(If rural, give LOCATION)

2(a) If veteran, name war None

3. (a) FULL NAME

* * * * * ALICE MAY HUBBARD * * * * *

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

Female White Single

6. (b) Name of husband or wife None

7. Birth date of deceased (mo., day, yr.) December 1st, 1865

8. AGE: Years Months Days If less than one day
82 82 1 10 hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation None

11. Industry or business None

12. Name Daniell Hubbard C

13. Birthplace Maryland

14. Maiden name Mary Elizabeth Cooke

15. Birthplace Maryland

16. Informant Mrs. Frank P. Jenkins (neice)

Address Rockville, Maryland

17. Burial Date thereof Jan. 20, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Old Cambridge Cemetery

Location Cambridge Maryland

18. Funeral director Wm. James Ruffin

Address Rockville, Maryland

19. 11/12 48 EP Shoups
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11, 1948 at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1947 to Jan. 11, 1948

and that I last saw him alive on January 10, 1948

Immediate cause of death Carcinoma of rectum

DURATION 1 year

Due to

Due to

Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

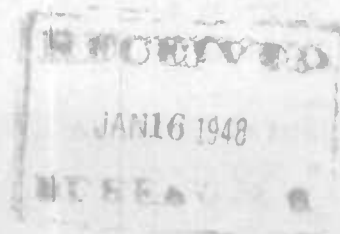
23. SIGNATURE W. J. Ruffin, M.D. M. D. or other

Address Rockville, Md. Date signed 1/11/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

830

00656

223

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County Montgomery
City or town Laurel, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, institution, or street address where death occurred: Washington San Hosp.
How long in hospital or institution? June 14, 1948 - 1-2-48

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Silver Spring - Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 409 Highland Drive
(If rural, give LOCATION)
2. (a) If veteran, name was

3. (a) FULL NAME

Hubbard, Mrs Lucy Marie

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Edward Carrington Hubbard
6. (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) June 26, 1875

8. AGE: Years 72 Months 6 Days 7 If less than one day .hrs. .min.

9. Birthplace Lynchburg, Va.
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business

12. Name JAMES WHITE

13. Birthplace VIRGINIA.

14. Maiden name HARRIET ARMSTEAD

15. Birthplace VIRGINIA.

16. Informant Mrs. Nellie Rittenhouse

Address Lakewood Park

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Jan 5, 1948

Cemetery or crematory Cedar Hill Cemetery

Location Phidias Palaces

18. Funeral director Phidias Palaces

Address 254 Carroll St., Takoma Park, D.C.

19. Jan 3 1948 J. H. H. D. H. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2 1948 at 10:32 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 26 to Jan 2 1948

and that I last saw her alive on Jan 2 1948

Immediate cause of death Cerebral Hemorrhage

Due to Arteriosclerosis

Due to Paralytic Agitation

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature D. V. K. Made M.D.

Address Lakewood Park, Md. Date signed 1-2-48

M. D. or other

1-2-48

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Do not correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 6 1948

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH:

County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 1/2 mos.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 11 Philadelphia Ave.
(If rural, give LOCATION)
2.(a) if veteran, name war NONE

3. (a) FULL NAME

FREDERIC HUNSINGER

3. (b) Social Security Number

579-16-9146

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widower
6.(b) Name of husband or wife Ilda M. Hunsinger
7. Birth date of deceased (mo., day, yr.) Oct. 18, 1866 6.(c) If alive, give age _____ years
8. AGE: Years 81 Months 3 Days 13 If less than one day _____ hrs. _____ min.

9. Birthplace Mt. Easton, Ohio
(Town, county, and state)

10. Usual occupation Railroad Engineer

11. Industry or business Retired

FATHER 12. Name Simon Hunsinger
13. Birthplace Ohio

MOTHER 14. Maiden name Lucetta Clawson
15. Birthplace Ohio

16. Informant Mr. Belford Hunsinger
Address 1376 Forest Rd. N.W., Wash. D.C.

17. Burial Burial Date thereof Feb. 2 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Ft Lincoln Cem

Location S.H. Hines Co.

18. Funeral director S.H. Hines Co.
Address 2901-14th St. N.W., Wash. D.C.

19. Jan. 31 1948 J. F. McLean Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31 1948 at 8:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 Sept. 1947 to 31 Jan. 1948
and that I last saw him alive on 30 Jan. 1948

Immediate cause of death Myocardial right leg. DURATION 3 days.

Due to Thrombosis Right Femoral Artery 3 days.

Due to Senile Arteriosclerosis 8-10 years.

Other conditions Chronic Myocarditis 8-10 years.

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
Means of injury _____ injured at work?

23. SIGNATURE J. F. McLean M.D.
Address Takoma Park, Md Date signed 31 Jan 48
M. D. or other _____

MARGIN RESERVED FOR BINDING

VS-A15

9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The street age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 3 1948

BUREAU v

Evidence for change of age
and birthdate shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

942

00658

2/3

FILM No. G 111 FEB 24 1948

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County... Montgomery

City or town... Rockville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Sudden Death

Hospital, institution, or street address where death occurred:
405 W. Montgomery Avenue,

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... District of Columbia County... Montgomery

City or town... Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3900 North Hampton, N. W.

(If rural, give LOCATION)

None

2.(a) If veteran, name war

3. (a) FULL NAME

Sarah L Hunter

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife... Henry L. Hunter

7. Birth date of
deceased (mo., day, yr.)

February 12, 1878 1869

6. (c) If alive, give age... years

8. AGE:

Years

Months

Days

It less than one day

79

78

11

15

hrs.

min.

9. Birthplace... Wisconsin
(Town, county, and state)

10. Usual occupation... Housewife

11. Industry or business... None

FATHER

12. Name... Franklin Lord

13. Birthplace... Unknown

MOTHER

14. Maiden name... Delphine Cassini

15. Birthplace... New York

16. Informant... Allison Chapin

Address 405 W. Montgomery Ave., Rockville

17. Burial

Date thereof... Jan. 30, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory... Glenwood Cemetery

Location... Washington, D. C.

18. Funeral director... Wm. William Pumphrey

Address... Bethesda, Maryland

19. Jan. 30 19 48

(Date rec'd by registrar)

W. W. Pumphrey
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Jan. 27 19 48, at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 19, 1948 to Jan. 27, 1948
and that I last saw him alive on Jan. 27, 1948

Immediate cause of death...

DURATION

Coronary occlusion

Found dead in bed

Due to...

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Frank J. Broschart M.D.
Address... Gaithersburg, Md. Date signed... 1-27-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 3 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 716

00659

1. PLACE OF DEATH:

County MontgomeryCity or town Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs

Hospital, institution, or street address where death occurred:

9129 Jones Mill RoadHow long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No. 9129 Jones Mill Road

(If rural, give LOCATION)

2.(a) If veteran, name war No

3. (a) FULL NAME

Mr. John Franklin Hurdle

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Alice B. Hurdle

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) October 8, 1863

8. AGE: Years Months Days If less than one day

84229

_____ hrs. _____ min.

9. Birthplace Washington, D. C.

(Town, county, and state)

10. Usual occupation Retired11. Industry or business None12. Name James Richard Hurdle13. Birthplace Washington, D. C.14. Maiden name Catherine Murray15. Birthplace Washington, D. C.16. Informant Mrs. Margaret SkinnerAddress 57 Crittenden Street, N. W.17. Burial Date thereof Jan. 10, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill CemeteryLocation Maryland18. Funeral director Wm. Louder HumphreyAddress Bethesda, Maryland19. 1/9 19 48 Wm E Jones

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7th 19 48, at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 14 19 45, to Jan 7 19 48and that I last saw him alive on Jan 6 19 48Immediate cause of death Wernia

DURATION

3 daysDue to Underlying cause: unknown (2/18/48 also)

Due to _____

Other conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Bradley D. Hodges MDAddress 313 Bradley Blvd., Chevy Chase, MarylandDate signed 1/7/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 15 1948

BT 8543

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

1. PLACE OF DEATH

County Montgomery Registration Dist. No. 212
 Village or City Towson No. 48 St. Ward
 Length of residence in city or town where death occurred 48 yrs. 1 mos. 3 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME

(a) Residence: No. 00660 St. Ward
 (Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5a. If married, widowed, or divorced
 HUSBAND of
 (or) WIFE of

6. DATE OF BIRTH (month, day, and year) Dec 4, 1899

7. AGE Years 49 Months 1 Days 5 If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year) March 1948

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Montgomery
 (State or country)

13. NAME Sevris Brampton

14. BIRTHPLACE (city or town) Montgomery
 (State or country)

15. MAIDEN NAME Belle Davis

16. BIRTHPLACE (city or town) Montgomery
 (State or country)

17. INFORMANT (Address)

18. BURIAL, CREMATION, OR REMOVAL Place Floresville Date Jan 12, 19 48

19. UNDERTAKER Charles H. Davis
 (Address) Baltimore, Md.

20. FILED Jan 12, 19 48 Montgomery
 Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

January 8, 19 48
 (Month) (Day) (Year)

22. I HEREBY CERTIFY That I attended deceased from Jan 3, 19 48, to Jan 8, 19 48
 I last saw him live on Jan 3, 19 48; death is said to have occurred on the date stated above, at 10 A.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Congestive Heart Failure
Generalized atherosclerosis
cardio-vascular - renal
disease

Date of onset

Other Contributory Causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury , 19

Where did injury occur?

(Specify city or town, county and State)
 Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) A. Adams M. D.

(Address) Baltimore, Md.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
-------------------	--------------------

Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
------------------------	---------------

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00661

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery
 City or town Olney, Maryland
 (if outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address, where death occurred:

The Montgomery County General Hospital Inc.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Olney
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Albera Jackson

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.)

April 11, 1881

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

66822

hrs.

min.

9. Birthplace

Dayton, Ohio
(Town, county, and state)

10. Usual occupation

Cook

11. Industry or business _____

MOTHER

12. Name

UNKNOWN

13. Birthplace

UNKNOWN

14. Maiden name

15. Birthplace

16. Informant

Hospital records

Address

Burial

17. (Burial, cremation, or removal. Which?)

Date thereof

Jan. 27, 1948
(month) (day) (year)

Cemetery or crematory

Location

Dayton, Ohio

18. Funeral director

Robert W. Snowden

Address

246-N-Wash-St. Rockville, Md.

Jan 26

1948

Gertrude B. Lawler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 3, 1948 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12-31-

19

47

to

1-3

19

48and that I last saw him alive on January 3, 1948

Immediate cause of death

Pulmonary Embolism

DURATION

15 minutes

Due to

Coronary Occlusion3 days

Due to _____

Other conditions

Hypertensive Cardiac vascular? years

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____

Date of _____

Where did injury occur? _____

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

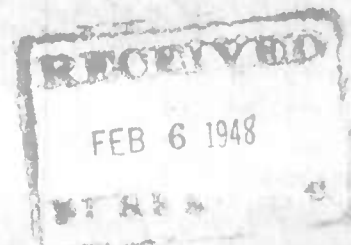
Injured at work? _____

23. SIGNATURE

Sandy Spring, Md

M. D. or other

Address Sandy Spring, Md Date signed 1/3/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

00662

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D.C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2904 Alabama Avenue, S.E.
 (If rural, give LOCATION)
 2. (a) If veteran, name war WWI

3. (a) FULL NAME

JENKINS, William

3. (b) Social Security Number

4. Sex Male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Elsie M. Jenkins
 7. Birth date of deceased (mo., day, yr.) January 2, 1898
 8. AGE: Years 50 Months 0 Days 10 If less than one day _____ hrs. _____ min.
 9. Birthplace Wash., D.C.
 (Town, county, and state)
 10. Usual occupation Engineer, Justice Dept.
US Government
 11. Industry or business _____
 12. Name Arthur Jenkins dec Va.
 13. Birthplace _____
 14. Maiden name Adalie Ingram dec Va.
 15. Birthplace _____

16. Informant wife: Mrs. Elsie M. Jenkins
 Address 2904 Alabama Ave., S.E., Wash., D.C.
 17. burial Date thereof 1-16-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Cedar Hill
 Location Washington, D.C.
 18. Funeral director S. H. HINES C. H. Hill
 Address 2901 14th St., N.W., Wash., D.C.
1-13 48 Mary C. Patterson
 (Date rec'd by registrar) Registrar

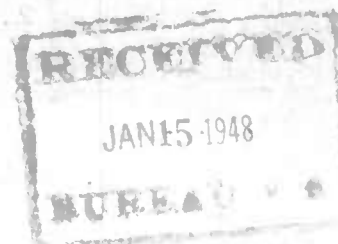
MEDICAL CERTIFICATION

20. DATE OF DEATH January 12 19 48 at 8 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
2 January 19 48 to 12 January 19 48
 and that I last saw him alive on 12 January 19 48

Immediate cause of death _____ DURATION
Pericarditis 10 days
Diabetes Mellitus 5 yrs
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results was permitted
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury R. E. Fleck Injured at work? _____
R. E. FLECK, Lt. MC USN
 23. SIGNATURE _____ M. D. or other _____
USNH Bethesda, Md. 1-13-48
 Address _____ Date signed _____



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

163M

00663

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH:

County MontgomeryCity or town Chevy Chase,
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Bradley Blvd.How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County WashingtonCity or town Washington
(If outside city or town limits, write RURAL and give nearest town)Street No. 3051 Idaho Ave., N. W.

(If rural, give LOCATION)

Unknown

2.(a) If veteran, name war

3. (a) FULL NAME

Albert E. Johnson

3.(b) Social Security Number

unknown

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Helen Marston Johnson6. (c) If alive, give age 1? years7. Birth date of deceased (mo., day, yr.) November 25, 1900

8. AGE:

Years

Months

Days

If less than one day

4747116

hrs.

min.

9. Birthplace Florida

(Town, county, and state)

10. Usual occupation Radio Engineer11. Industry or business Radio12. Name Rollo H. Johnson13. Birthplace Florida14. Maiden name Ellen Currey15. Birthplace Florida16. Informant Helen M. Johnson (wife)Address Washington, D.C.17. Removal Date thereof Jan. 12, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Gawler Funeral HomeLocation Washington, D.C.18. Funeral director W. Reuben HumphreyAddress Bethesda, Maryland19. January 12, 48
(Date rec'd by registrar)Wm E Jones
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 11 1948 at 11:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept med exam case 19... to 19...
and that I last saw him alive on 19...

Immediate cause of death

Carbon monoxidepoisoningDue to Suicide

Due to...

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 1-11-48Where did injury occur? Bethesda Montgomery MD
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Frank J. Broschart M.D.Sept med exam M. D. or otherAddress Washington Date signed 1-12-48

DURATION

Found dead in car.

RECEIVED

JAN 20 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13/a

00664

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH

County Montgomery
 City or town germantown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Pa. County Montgomery
 City or town germantown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Charles Thomas Johnson

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Jennie Elizabeth Johnson

7. Birth date of deceased (mo., day, yr.)

May - 12 - 1867

6. (c) If alive, give age _____ years

8. AGE:

Years

80

Months

7

Days

23

If less than one day

— hrs. — min.

9. Birthplace

Clarksburg, Md.

(Town, county, and state)

10. Usual occupation

postmaster

11. Industry or business

postal

FATHER

12. Name

James Johnson

13. Birthplace

unknown

MOTHER

14. Maiden name

unknown

15. Birthplace

unknown

16. Informant

Wm Jane Benson

Address

220 W. Maryland St., Cherry Chase, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof January 6, 1948

(month) (day) (year)

Cemetery or crematory

Cedar Grove Baptist Cemetery

Location

Cedar Grove, Maryland

18. Funeral director

W. Reuben Thompson

Address

Bethesda, Maryland

19. Jan 5

(Date rec'd by registrar)

19 48

Abudal S. Cook

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

January - 4 - 1948 at 10:35 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January - 3 - 1948 to January - 4 - 1948and that I last saw him alive on January - 4 - 1948

Immediate cause of death

central hemorrhage

DURATION

17 hours

Due to

high arterial tension

Due to

gas

Due to

Cardio - nephritic

Other conditions

6 - mo -

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William C. Miller, M.D.

M. D. or other

Address Gaithersburg, Md. Date signed 1-4-48

RECEIVED

JAN 7 1948

ST. LOUIS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

956

00665

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? one day
 Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland
 How long in hospital or institution? one day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Park Lane Apts., 21st and Pa., NW
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

JOHNSON, Jeanette Smith

3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed
 6. (b) Name of husband or wife _____
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) 8 April 1881
 8. AGE: Years 66 Months 9 Days 2 If less than one day _____ hrs. _____ min.

9. Birthplace Indiana
 (Town, county, and state)

10. Usual occupation None

11. Industry or business _____

12. Name Edward H. Smith

13. Birthplace Indianan, Dec.

14. Maiden name Ellen Moore

15. Birthplace Indiana, Ded.

16. Informant Son: Albert E. Johnson

Address Park Lane Apts., 21st and Pa. NW,

17. (burial) Washington, D. C. Date thereof Jan. 11, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____

Location Vincennes, Ind.

18. Funeral director S. H. HINES FUNERAL HOME #69.

Address 2901 14th ST., NW, Washington, D. C.

1-10-48 Mary C. Patterson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 January 19 48 at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 Jan 19 48 to 10 Jan 19 48 and that I last saw him alive on 10 Jan 19 48

Immediate cause of death Congestive heart failure
Rheumatic heart disease DURATION 28 yrs.

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results Confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury WA Injured at work? _____

23. SIGNATURE W. A. DINSMORE, Jr., LCDR ME USN
 M. D. or other _____

Address USNH Bethesda, Md. Date signed 1-10-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

85

00666

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 16 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Va. County _____
 City or town Lynchburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1105 East Grand Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war WWI ✓

3. (a) FULL NAME

JONES, Earl Eunice

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Ernest Moorefield Jones
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) May 15, 1893
 8. AGE: Years 54 Months 8 Days 0 if less than one day _____ hrs. _____ min.

9. Birthplace Va.
 (Town, county, and state)
 10. Usual occupation Patcher
 11. Industry or business _____
 12. Name JONES, Elishia Thomas dec.
 13. Birthplace Va.
 14. Maiden name ELIA, Lucy dec.
 15. Birthplace Va.

16. Informant Wife: Mrs. Ernest M. Jones
 Address 1105 East Grand Avenue, Lynchburg, Va.
 17. burial Date thereof _____ (month) (day) (year)
 (Burial, cremation, or removal, Which?)
 Cemetery or crematory Spring Hill
Lynchburg, Va.
 Location _____
 18. Funeral director W. W. CHAMBERS
 Address Georgetown, D.C.
 19. 1-15 48 Mary E. Patterson
 (Date rec'd by registrar) 19 _____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 January 19 48 at 9:30 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
31 Dec. 19 47 to 15 Jan. 19 48
 and that I last saw him alive on 15 January 19 48

Immediate cause of death Circulatory Collapse DURATION 9 hrs.
 Due to Ventricular Fibrillation Sudy.
 Due to _____
 Other conditions Epilepsy, Post Traumatic 28 yrs.
 (Include pregnancy within 3 months of death)

Major findings of operations None
 Date of op. _____
 Autopsy results Artificial Stomach, Rt. Impureal hole.
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury Wade H. Boswell Injured at work? _____
 23. SIGNATURE W. H. BOSWELL, Lt. MC USN
 M. D. or other _____
 Address USNH Bethesda, Md. Date signed 1-15-48

RECEIVED

JAN 19 1948

SECRET

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
47c
2411 N. Charles St., Baltimore
CERTIFICATE OF DEATH

00667

r 14

Reg. Dist. No.

1. PLACE OF DEATH:

County MontgomeryCity or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Household or other street address where death occurred:

733 Thayer Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)Street No. 733 Thayer Ave.
(If rural, give LOCATION)2.(a) If veteran, name war no

3. (a) FULL NAME

Mrs. Eva Duley Jones

3. (b) Social Security Number

none

4. Sex

female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married6.(b) Name of husband or wife Edward D.

6.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Aug. 27th. 1865

8. AGE:

Years

Months

Days

If less than one day

8252

hrs.

min.

9. Birthplace Washington, D. C.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
MOTHER12. Name David C. Duley13. Birthplace Washington, D. C.14. Maiden name Mary E. McChesney15. Birthplace Washington, D. C.16. Informant Mrs. Florence MageeAddress 730 Thayer Ave. Silver Spring.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 1/31/1948

(month) (day) (year)

Cemetery or burying place St. JohnsLocation Olney, Montg. Co. Md.18. Funeral director Werner & Rumphrey, Inc.Address Silver Spring, Md.19. January 31, 1948
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 29 1948 at 9:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 2 1947, to Jan 29 1948and that I last saw him alive on Jan 29 1948

Immediate cause of death

Bronchogenic carcinoma

DURATION

Due to

Due to

Other conditions

Secondary anemia

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Maria Bonhead M.D.
9601 Britton Ave
Address Silver Spring, Md. Date signed 1-29-48

RECEIVED

FEB 3 1948

W. B. A.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 00668223

1. PLACE OF DEATH:

County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 days 17 hrs 40 min
Hospital, institution, or street address where death occurred:
Washington San & Hosp Takoma Park
How long in hospital or institution? 9 days 17 hrs 40 min

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State D.C. County D.C.
City or town Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1603 Hubert St. N.W. D.C.
(If rural, give LOCATION) ☒
2.(a) I veteran, name war ☒

3. (a) FULL NAME

Anna M. Kearney

3. (b) Social Security Number

4. Sex F 5. Color or race White 6.(a) Single, married, widowed, or divorced Separated.
6.(b) Name of husband or wife John Kearney
6.(c) If alive, give age 7-26-1877 years
7. Birth date of deceased (mo., day, yr.) 7-26-1877
8. AGE: Years 70 Months 5 Days 12 If less than one day 8 hrs. 42 min.

9. Birthplace Frankenstine, Germany
(Town, county, and state)

10. Usual occupation House wife.

11. Industry or business

12. Name Joseph Schaffer.

13. Birthplace Frankenstine, Germany

14. Maiden name Anna Vogt.

15. Birthplace Frankenstine, Germany

16. Informant Hosp. Records.

Address Washington San & Hosp.

17. (Burial, cremation, or removal. Which?) Burial Date thereof 1-10-48
(month) (day) (year)

Cemetery or crematory Fort Lincoln

Location S.H. Hines Co.

18. Funeral director S.H. Hines Co.

Address 2901-14th St. N.W.

19. Jan 8 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8 1948 at 8:43 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 3 1947 to Jan 8 1948
and that I last saw him alive on January 8 1948

Immediate cause of death Congestive Cardiac Failure DURATION Terminal

Due to Coronary Occlusion 2 wks

Due to Arteriosclerosis years

Other conditions Diabetes Mellitus 15 yrs

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results X

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert A. Hare M.D. M.D. or other

Address Takoma Park Md. Date signed 1/8/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 10 '48
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00669

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo., 18 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.How long in hospital or institution? 1 mo., 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. CountyCity or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1319 Delfield Place, N.W.

(If rural, give LOCATION)

2. (a) If veteran, name war Sp. Am. & WWI ✓

3. (a) FULL NAME

KELLOGG, Edward Stanley, Capt. USN Ret. Inactive

3. (b) Social Security Number

4. Sex

male

5. Color or race

W-US

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

August 20, 1870

8. (c) If alive, give age

8. AGE: Years Months Days If less than one day

77

4

18

hrs.

min.

9. Birthplace

New York

(Town, county, and state)

10. Usual occupation

Retired Navy

11. Industry or business

12. Name KELLOGG, Edward N. dec.13. Birthplace Maine14. Maiden name POLLOCK, Janie dec.15. Birthplace England16. Informant cousing: Miss Jenie B. McEwenAddress 1919 Delfield Place, N.W., Wash., D.C.17. burial Date thereof 1-12-48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington nationalLocation Arlington, Va.18. Funeral director Joseph Gawler R. J. H.Address 1750 Penn. Avenue, N.W., Wash., D.C.19. 1-8- 48 Mary C. Patterson

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 January 19 48 at 9:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 20 19 47 to 8 January 1948and that I last saw him alive on 8 January 19 48

Immediate cause of death

Myocardial infarction

DURATION

1 wkDue to Coronary Heart Disease, Arterio-sclerotic

indef.

Due to Hypertension Arterial

indef

Other conditions Pulmonary Infarction;Bronchopneumonia3 days3 days

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury T. E. JARRETT, MC USN injured at work?23. SIGNATURE T. E. JARRETT, MC USNAddress USNH Bethesda, Md.Date signed 1-8-48

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 14 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1218 Rigges St., N.W.
 (If rural, give LOCATION)
 2(a) If veteran, name war WWI

3. (a) FULL NAME

KNIGHT, Frank Whaley

3. (b) Social Security Number

4. Sex male 5. Color or race Col. 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Mary Knight
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) March 26, 1896
 8. AGE: Years 51 Months 10 Days 4 If less than one day _____ hrs. _____ min.

9. Birthplace N.C.
 (Town, county, and state)
 10. Usual occupation unknown
 11. Industry or business _____
 12. Name KNIGHT, ? dec. dec.
 13. Birthplace N.C.
 14. Maiden name Anne ?
 15. Birthplace N.C.

16. Informant Wife: Mrs. Mary Knight
 Address 1218 Rigges St., N.W., Wash., D.C.
 17. burial Date thereof 2-3-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Arlington National
 Location Arlington, Va.
 18. Funeral director Hall Brothers Funeral Home S.W.D.
 Address 621 Florida Avenue, NW, Wash., D.C.
 19. 1-31 48 Mary C. Patterson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30, 1948 at 10:15A
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 16, 1948 to January 30, 1948
 and that I last saw him alive on 30 January, 1948
 Immediate cause of death Bronchopneumonia

DURATION 4 days
 Due to Multiple Neuritis 6 mos
 Due to _____
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results Confirmed above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE W. A. Dinsmore W. A. DINSMORE, LCDR MC USN
 M. D. or other _____
 Address USNH, Bethesda, Md. Date signed 1-31-48

RECEIVED

FEB 3 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00671

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MONTGOMERY
 City or town Chevy Chase, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 29 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MARYLAND County MONTGOMERY
 City or town Chevy Chase
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 22 Hesketh Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

John Adam Koons

3. (b) Social Security Number

NONE

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife

HELEN G. KOONS

7. Birth date of deceased (mo., day, yr.)

October 5 1869 70

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

77313

hrs.

min.

9. Birthplace

Washington D.C.
(Town, county, and state)

10. Usual occupation

OWNER

11. Industry or business

Koons Roofing Co.

MOTHER

12. Name

HENRY A. KOONS

13. Birthplace

GERMANY

14. Maiden name

Elizabeth Arth

15. Birthplace

GERMANY

16. Informant

Mrs. LENA U. McINNESAddress 3631-49th STREET N.W. WASH. D.C.

17. (Burial, cremation, or removal. Which?)

BURIALDate thereof JAN. 21 1948
(month) (day) (year)

Cemetery or crematory

Prospect Hill

Location

Washington D.C.

18. Funeral director

The S. J. Jones Co.Address 2901-14th Street N.W.

19. (Date fee'd by registrar)

1/18

19

48Wm E Jones

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

January 18 1948 at 6:50 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 18 1948 to January 18 1948
and that I last saw him alive on January 18 1948

Immediate cause of death

Coronary Thrombosis

DURATION

1 1/2 hours

Due to

Arteriosclerosis (Coronary)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

NONE

Date of _____

Where did injury occur?

NONE

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

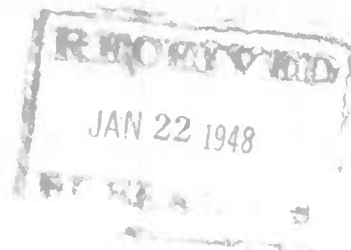
Samuel B. (Eugene) M. D.

M. D. or other

Address 1801 Eye Street NWDate signed 1/18/48

Careed Dr. Frank J. Broochard
re this death on 1/18/48 at 7:55
and be verbally cleared on this
death certificate.

Layton B. Feunoy M.D.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

00672

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

4215 Curtis Rd.,

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Montgomery

City or town Bethesda
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 4215 Curtis Rd.,

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Sarah W. Landenberger

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband ~~xxxx~~ George W. Landenberger

7. Birth date of deceased (mo., day, yr.)

Dec., 11, 1860

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

87

..... hrs. min.

9. Birthplace

Philadelphia, Pa.

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

MOTHER FATHER

12. Name

Edward Burns

13. Birthplace

Ireland

14. Maiden name

Jennie Greene

15. Birthplace

Ireland

16. Informant

Mrs. Viola C. Milne,

Address

4215 Curtis Rd., Bethesda, Md.

17.

Burial

(Burial, cremation, or removal, Which?)

Date thereof

1/5/48

(month) (day) (year)

Cemetery or crematory

xxxxx Philadelphia, Pa.

Location

18. Funeral director

Address

5103 Wis. Ave., Washington, D.C.

19.

1-4-48

(Date rec'd by registrar)

19.

W.E. Jones.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 Jan 1948 at 3³⁰ A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

15 Oct1947to 4 Jan1948and that I last saw ~~h.s.~~ alive on 3 Jan 1948Immediate cause of death cardiac failure

DURATION

3 weeks

Due to

Carcinoma, generalized including metastases5 yrs

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Herbert Martin Jr. M.D.

Address

1332 Mass. Ave. N.W.

Date signed

4 Jan 48

RECEIVED

JAN 6 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00673

Reg. Dist. No. 218

1. PLACE OF DEATH:

County..... Montg Co,
City or town..... Germantown Md, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 35yrs
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State..... Md. County..... Montgomery
City or town..... Germantown, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

John Upton Leaman

3. (b) Social Security Number

4. Sex..... Male 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Widower
6.(b) Name of husband or wife..... Augusta Leaman
7. Birth date of deceased (mo., day, yr.)..... May 16th 1878
6.(c) If alive, give age..... years
8. AGE: Years..... 69 Months..... 8 Days..... 8 If less than one day..... hrs. min.

9. Birthplace..... Germantown Md,
(Town, county, and state)
10. Usual occupation..... Retired Farmer
11. Industry or business..... "

12. Name..... Christain Leaman
13. Birthplace..... Md,
14. Maiden name..... Martha Young
15. Birthplace..... Md,

16. Informant..... Miss Rebecca Leaman
Address..... Germantown Md,

17. Burial, cremation, or removal. Which?..... Date thereof..... 1/27/48
(month) (day) (year)
Cemetery or crematory..... Neelsville, Cemetery
Location..... Germantown Md, R.F.D.,

18. Funeral director..... Ernest C Gartner
Address..... Gaithersburg Md,

19. Date rec'd by registrar..... 1/26/48
Registrar..... R. Suda I Cooke

MEDICAL CERTIFICATION

20. DATE OF DEATH..... January - 29 - 1948, at 7:45 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June - 1 - 1947 to Jan - 24 - 1948
and that I last saw him alive on Jan 8 19 - 1948
Immediate cause of death..... acute heart failure
DURATION..... 1/2 hour
Due to..... myocystial degeneration 7ms
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of
Where did injury occur?..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury..... Injured at work?

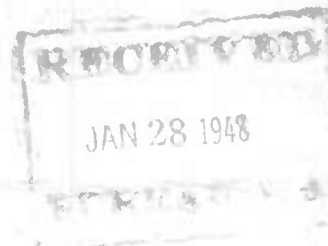
23. SIGNATURE..... William C. Miller, M.D.
M. D. or other
Address..... Gaithersburg, Md Date signed..... 1-26-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death clearly and legibly is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 229

1. PLACE OF DEATH:

County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred:
Washington Sanitarium and Hospital
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Kensington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9 McComas Ave
(If rural, give LOCATION)
2. (a) If veteran, name war none

3. (a) FULL NAME

Mrs. Inez Mary Lee

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Robert E. Lee
6. (c) If alive, give age 7 years
7. Birth date of deceased (mo., day, yr.) Aug. 9, 1872
8. AGE: Years 75 Months 5 Days 4 It less than one day hrs. min.

9. Birthplace Indian Spring, Maryland
(town, county and state)
10. Usual occupation Housewife
11. Industry or business none
FATHER 12. Name Charles C. Coupard
13. Birthplace Va.
MOTHER 14. Maiden name Isabel Thompson
15. Birthplace Md.

16. Informant Washington Sanitarium Records
Address Takoma Park, Maryland
17. Burial Date thereof Jan. 16, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St. James Catholic Church Cemetery
Location Forest Ridge, Maryland
18. Funeral director Wm. Henderson Humphrey
Address Bethesda, Md.
19. Jan. 14, 1948 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13 19 48 at 9:37 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9:36 to Jan 13 19 48
and that I last saw her alive on Jan 13 19 48

Immediate cause of death Bronchopneumonia
DURATION 1 week
Due to
Due to
Other conditions Senile secondary anemia (concomitant)
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James Burchhead MD M. D. or other
Address 9601 Dutton Rd.
Date signed 1/13/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 16 1948
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00675

Reg. Dist. No. 223

1. PLACE OF DEATH:

County MONTGOMERY
 City or town Laurens Park, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 hrs.

Hospital, institution, or street address where death occurred:

Washington Sanitarium & HospitalHow long in hospital or institution? 6 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia CountyCity or town Washington
(If outside city or town limits, write RURAL and give nearest town)Street No. 6810 - 9th St. NW.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Louise R. Lester

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) February 28, 1884.

8. AGE:

Years

Months

Days

If less than one day

63110— hrs.

min.

9. Birthplace Columbia, South Carolina
(Town, county, and state)10. Usual occupation Retired - Government Worker

11. Industry or business

12. Name William Preston Lester13. Birthplace Columbia, S. Carolina14. Maiden name Minnie North15. Birthplace S. Carolina16. Informant Sanitarium Records

Address

17. Burial Date thereof Jan 30, 1948
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory Cedar Hill CemeteryLocation Prince George Co., Md.18. Funeral director The W. H. Hines Co.Address 2901 14th St. NW19. Jan 28, 1948 Date rec'd by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28, 1948 at 5:12 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 12, 1947 to Jan 28, 1948 and that I last saw him alive on Jan 27, 1948

Immediate cause of death

Acute Cardiac Failure

DURATION

Due to Coronary ThrombosisDue to Arteriosclerotic Heart Disease

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

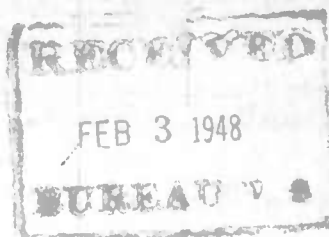
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Dean W. Harding, M.D. D. or other
113 Carroll St. NW Address Wash DC Date signed 1-28-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00675
216

1. PLACE OF DEATH:

County Montgomery
City or town Kensington
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
City or town Kensington
(If outside city or town limits, write RURAL and give nearest town)Street No. 60 Concord St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Loehler Mustav Mottlich

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Marie J. Loehler7. Birth date of deceased (mo., day, yr.) June 1 18946. (c) If alive, give age 72 years8. AGE: Years 73 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Germany
(Town, county, and state)10. Usual occupation Bldg Inspector

11. Industry or business

12. Name ?13. Birthplace Germany14. Maiden name ?15. Birthplace Germany16. Informant John H. LoehlerAddress 698 Rollingwood Chase17. (Burial, cremation, or removal, Which?) Burial Date thereof 1-29-48
(month) (day) (year)Cemetery or crematory Cedar HillLocation Wash. H.C. Md18. Funeral director W. H. Hines CoAddress 2901-14 St N W19. 1/26/48 Thos E Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/26/48 19____ at 5 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/25/47 19____ to 1/26/48 19____and that I last saw him alive on 1/26/48 19____Immediate cause of death Cardiac Failure

DURATION

2 monthsDue to arteriosclerosis, generalized and yrs.Hypertension

Due to _____

Other conditions Diabetes Mellitus 10 yrs.

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Samuel Allen MD M. D. or otherAddress Kensington Md Date signed 1/26/48

Handwritten text, possibly a signature or address, located in the upper left corner.

Handwritten text, possibly a signature or address, located in the upper right corner.

Handwritten text, possibly a date or reference number, located in the center of the page.

RECEIVED
JAN 29 1948
BUREAU

Handwritten text, possibly a signature or address, located in the lower center of the page.

Handwritten text, possibly a signature or address, located in the lower right corner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 217

I. PLACE OF DEATH:

County MontgomeryCity or town Piney, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital Inc.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Rockville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mr. Carroll Long

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Mrs. Vivian Long6.(c) If alive, give age 28 years

7. Birth date of

deceased (mo., day, yr.)

September 24, 1912

8. AGE:

Years

Months

Days

If less than one day

35323

hrs.

min.

9. Birthplace

Sunlight, Virginia

(Town, county, and state)

10. Usual occupation

Blacklayer

11. Industry or business

FATHER

MOTHER

12. Name

Fred Franklin Long

13. Birthplace

Sunlight, Virginia

14. Maiden name

Susie Waller

15. Birthplace

Sunlight, Virginia

16. Informant

Hospital records

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

Jan 20, 1948
(month) (day) (year)

Cemetery or crematory

Arlington National Cem

Location

Fort Myer, Va

18. Funeral director

W. H. Chambers Co

Address

5801 Cleveland Ave, Riverdale, Md

19.

Date rec'd by registrar

19. 48

Gertrude B. Lawler

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17, 1948 at 10:51 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

January 11, 1948 to January 17, 1948and that I last saw him alive on January 17, 1948

Immediate cause of death

Shock

Due to

Intestinal obstruction

Due to

Incarcerated ventral hernia

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Same as aboveDate of op. 1-11-48

Autopsy made

and 1-17-48

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

[Signature]

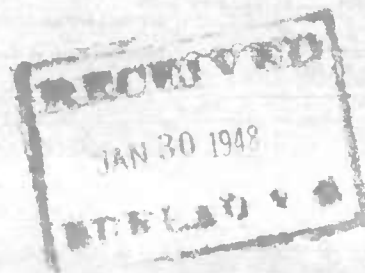
M. D. or other

Address

Sandy Spring, Md

Date signed

1/17/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

00678

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 22 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State D.C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 229 Webster St., N.W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war WWI

3. (a) FULL NAME

LOWDER, Bernard Smith

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Ellen J. Lowder
 7. Birth date of deceased (mo., day, yr.) August 24, 1899
 8. AGE: Years 48 Months 4 Days 25 If less than one day _____ hrs. _____ min.

9. Birthplace Charlotte, N.C.
 (Town, county, and state)
 10. Usual occupation Civil Engineer
 11. Industry or business _____

12. Name LOWDER, John A. dec.
 13. Birthplace N.C.
 14. Maiden name SMITH, Ella, dec.
 15. Birthplace N.C.

16. Informant wife; Mrs. Ellen J. Lowder
 Address 229 Webster St., N.W., Wash., D.C.
 17. burial Date thereof 1-22-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Arlington National
 Location Arlington, Va.

18. Funeral director W. W. CHAMBERS
 Address 1400 Chapin St., N.W., Wash., D.C.
Mary C. Patterson
 19. 1-20 48 Mary C. Patterson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 January 19 48 at 7:10 P.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 29 Dec. 19 47 to 19 Jan 19 48
 and that I last saw him alive on 19 January 19 48

Immediate cause of death Hemorrhage, esophageal
continuity of liver, atrophic
 Due to _____
 Due to _____
 Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____
 Date of op. _____
 Autopsy results Same as above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE W. F. Queen
W. F. QUEEN, Cdr. MC USN
 M. D. or other _____
 Address USNH Bethesda, Md. Date signed 1-20-48

RECEIVED

JAN 22 1948

ST. LOUIS, MO.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2/3

1. PLACE OF DEATH:

County Montgomery
City or town Rural - Dawsonville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 months
Hospital, institution, or street address where death occurred:
Off Route 28 Dawsonville
How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County MONTGOMERY
City or town RURAL DAWSONVILLE
(If outside city or town limits, write RURAL and give nearest town)
Street No. OLD SCHOOL HOUSE
(If rural, give LOCATION)
2.(a) If veteran, name war W

3. (a) FULL NAME

GEORGIA MAE LOWE

3. (b) Social Security Number

None

4. Sex FEMALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced WIDOW
6.(b) Name of husband or wife WILLIE LOWE - (DECEASED)
7. Birth date of deceased (mo., day, yr.) January 8, 1905 6.(c) If alive, give age 43 years
8. AGE: Years 43 Months 0 Days 21 If less than one day hrs. min.

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 January 1948 at 7:00 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 January 1948 to 29 Jan. 1948 and that I last saw her alive on 28 Jan. 1948
Immediate cause of death CARDIO-RESPIRATORY FAILURE
Due to DEBILITY
Due to EAR ADVANCED ACTIVE TUBERCULOSIS
Other conditions NONE

DURATION

4 weeks
3 weeks
17 years

9. Birthplace GERMAN TOWN MONTGOMERY Md.
(Town, county, and state)
10. Usual occupation HOUSE WIFE
11. Industry or business NONE
12. Name GEORGE LOWE BEST
13. Birthplace UNKNOWN EXCEPT U.S.A.
14. Maiden name FLORENCE MULLIGAN
15. Birthplace DICKERSON Md.

16. Informant ELINORA BURDETTE (daughter)
Address DAWSONVILLE, Md.
17. Burial Forest Oak Cemetery Date thereof Jan. 31, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Gaithersburg, Maryland
Location Bethesda, Maryland
18. Funeral director W. R. Thompson
Address Bethesda, Maryland

(Include pregnancy within 3 months of death)
Major findings of operations NONE
Date of op. None
Autopsy results NONE
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide None Date of None
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John J. Lawless M.D.
Address Dawsonville, Md. Date signed 29 Jan. 48

19. 1/30/48 19 W. R. Thompson
(Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 3 1948

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00680

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 hrs. 13 min.
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 10 hours, 13 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Va. County _____
 City or town Arlington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 216 N. George Mason
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

MAC DONALD, Roderick John

3. (b) Social Security Number

4. Sex Twin Male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced single
 6.(b) Name of husband or wife _____
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) January 23, 1948
 8. AGE: Years _____ Months _____ Days _____ If less than one day
10 hrs. 13 min.

9. Birthplace Bethesda, (rural), Md.
 (Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

12. Name MacDonald, John13. Birthplace Lowell, Mass.14. Maiden name CASTIGLIOLA, Christina C.15. Birthplace La.16. Informant Father: Lt.(jg) John MacDonald USNAddress 216 N. George Mason, Arl., Va.

17. burial Date thereof 1-26-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington NationalLocation Arlington, Va.18. Funeral director WW Chambers CoAddress Georgetown, D.C.

1-26 48 Mary G. Patterson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23 19 48 at 11:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
1-23 19 48 to 1-23- 19 48
 and that I last saw him alive on 1-23- 19 48

Immediate cause of death Premature (6 months) DURATION _____

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE PAUL PETERSON, Capt. MC USNAddress USNH Bethesda, Md. M. D. or other _____Date signed 1-26-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00681

Reg. Dist. No. 216

1. PLACE OF DEATH:

County..... Montgomery
 City or town..... Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 2 1/2 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution?..... 2 1/2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Va. County.....
 City or town..... Arlington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 216 N. George Mason,
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... ✓

3. (a) FULL NAME

MAC DONALD, Vincent Ian

3. (b) Social Security Number

4. Sex (Twin)..... male 5. Color or race..... W-US 6.(a) Single, married, widowed, or divorced..... single
 6.(b) Name of husband or wife.....
 7. Birth date of deceased (mo., day, yr.)..... January 23, 1948
 6.(c) If alive, give age..... years
 8. AGE: Years..... Months..... Days..... 2 1/2 hrs. min.

9. Birthplace..... Bethesda (rural) Md.
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name..... MACDonald, John13. Birthplace..... Lowell, Mass.14. Maiden name..... Castigliola, Christina C.15. Birthplace..... La.16. Informant..... father: Lt. (jg.) John MacDonaldAddress..... 216 N. George Mason, Arl., Va.17. (Burial, cremation, or removal, Which?)..... burial Date thereof..... 1-26-48

(Burial, cremation, or removal, Which?)..... (month) (day) (year)

Cemetery or crematory..... Arlington NationalLocation..... Arlington, Va.18. Funeral director..... W W Chambers COAddress..... Georgetown, D.C.19. 1-26 19 48 Mary C. Patterson

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 25 19 48 at 11:55 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
January 23 19 48 to January 25 19 48
 and that I last saw him alive on 1-25- 19 48

Immediate cause of death..... Premature (6 months) DURATION.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... PAUL PETERSON, Capt. MC USNAddress..... USNH Bethesda, Md. Date signed 1-26-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 00682 213

1. PLACE OF DEATH

County Montgomery
City or town Lincoln Park, Rockville, Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Henry T Manly

4. Sex

M

5. Color or race

C

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Edith Manly

7. Birth date of deceased (mo., day, yr.)

June 23, 1883

6. (c) If alive, give age 5 1/3 years

8. AGE:

Years

Months

Days

If less than one day

64

6

20

hrs.

min.

9. Birthplace

Raleigh, N.C.

(Town, county, and state)

10. Usual occupation

Watchmaker

11. Industry or business

FATHER

12. Name

Symethimus Manly

13. Birthplace

Raleigh, N.C.

MOTHER

14. Maiden name

Corine

15. Birthplace

Raleigh, N.C.

16. Informant

Edith Manly

Address

Lincoln Park, Rockville, Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Jan. 16th 1948

Cemetery or crematory

Lincoln Park

Location

Rockville, Md

18. Funeral director

Robert H. Snowden

Address

246 N. Wash. St. Rockville

19. 1-16

19-48

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED

For newborn infants give residence of mother

State

Maryland

County

Montgomery

City or town

Lincoln Park, Rockville, Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

January 13, 1948, at 6:30 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 9, 1933, to January 13, 1948

and that I last saw him alive on

December 29, 1947

Immediate cause of death

DURATION

Ruptured Peptic Ulcer

few minutes

Due to

Anemia & Hypotension uncertain

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Duodenal Ulcer 1933.

Date of op. 1933.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert Snowden M.D.

M. D. or other

Address

Rockville, Md. Date signed Jan 13, 48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 22 1948

GENERAL

1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00683 214

1. PLACE OF DEATH:

County.....Montgomery
 City or town.....Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Md. County.....Montgomery
 City or town.....Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....910 Sligo Ave.
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Frank Asbury Marden Jr.

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife.....Bertha M. Marden7. Birth date of deceased (mo., day, yr.)
Jan. 20, 18988. AGE: Years 49 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace.....Washington D. C.
(Town, county, and state)10. Usual occupation.....Naval Observatory Employee

11. Industry or business

12. Name.....Frank A. Marden13. Birthplace.....Md.14. Maiden name.....Lottie ?15. Birthplace.....Md.16. Informant.....Bertha M. MardenAddress.....910 Sligo Ave.17. Burial Date thereof.....Jan 23, 1948
(Burial, cremation, or removal) Which? (month) (day) (year)Cemetery or crematory.....Rock CreekLocation.....Washington, D. C.18. Funeral director.....Deal Funeral HomeAddress.....4812 Georgia Ave. N. W. D. C.19. Jan 20 1948 Josephine Schaeffer
Date rec'd by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....January 20 1948 at 3 a. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
June 29 1938 to Jan. 20 1948and that I last saw him.....Jan. 19 1948Immediate cause of death.....Pulmonary Tuberculosis

DURATION

Due to.....10 yrs.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE.....J. Smith M. D.Address.....1746 K St. N. W. Wash D.C. Date signed Jan 20 1948

Dr Wandlidge
1746 K N.W.

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CERTIFICATE OF DEATH

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JAN 23 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH ✓

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 months, 28 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 2 months, 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D.C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 101 Juliet St., S.E.
 (If rural, give LOCATION)
 2(a) If veteran, name war WWI ✓

3. (a) FULL NAME

MILES, Clyde Leon

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced widowed
 6. (b) Name of husband or wife Ethel Miles
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) 17 May 1881
 8. AGE: Years 66 Months 8 Days 5 If less than one day _____ hrs. _____ min.

9. Birthplace Vt. (Town, county, and state)
 10. Usual occupation Retired Naval Personnel
 11. Industry or business _____
 12. Name MILES, Otis dec.
 13. Birthplace Vt.
 14. Maiden name Smith, Mary dec.
 15. Birthplace Vt.

16. Informant neice: Mrs. Ora M. Wise
 Address 118 Roadside Avenue, Waynesboro, Pa.
 17. burial Date thereof 1-26-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Arlington National
Arlington, Va.
 Location Wm. J. Nalley
 18. Funeral director Wm. J. Nalley
 Address 3200 Rhode Island Avenue N.E., Wash., D.C.
Mary C. Patterson
 19. 1-23 48 Mary C. Patterson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 January 19 48 at 9:30 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 25 October 19 47 to 23 January 19 48
 and that I last saw him alive on 23 January 19 48
 Immediate cause of death urinary carcinoma, bladder DURATION ?
 Due to _____
 Due to _____
 Other conditions Diabetes mellitus ?
 (Include pregnancy within 3 months of death)
 Major findings of operations _____ Date of op. _____
 Autopsy results Confirmed above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury P.P. Bates Injured at work? _____
P. L. BATES, Lt. (jg) MC USN
 23. SIGNATURE _____ M. D. or other _____
USNH Bethesda, Md. Address _____ Date signed 1-23-48

RECEIVED

JAN 27 1948

STREET 18

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Cherry Chase
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md. County Montgomery
 City or town Cherry Chase
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 302 Taylor
 (If rural give LOCATION)
 2.(a) If veteran, name war 1st. W. W.

3. (a) FULL NAME

EVANS E MOECKEL

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 8. (b) Name of husband or wife Mary S. Moeckel
 7. Birth date of deceased (mo., day, yr.) July 10 - 1887
 8. AGE: Years 60 Months Days If less than one day
 hrs. min.

9. Birthplace Philadelphia - Pa.
 (Town, county, and state)
 10. Usual occupation Court Reporter

11. Industry or business
 12. Name Edwin E. Moeckel
 13. Birthplace Phila. - Pa.
 14. Maiden name Theresa Shoosmith
 15. Birthplace Phila. - Pa.

16. Informant Edwin D. Sampson
 Address 1701-16th - N.W.

17. Burial Date thereof 1-27-48
 (Burial, cremation, or removal Which?) (month) (day) (year)
 Cemetery or crematory Arlington Natl
 Location Arlington, Va.

18. Funeral director Frank Martin's Sons Inc.
 Address 1786 - Conn. Ave.

19. 426 19 728 Thos E Jones
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 25 19 48 at 7:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 19 39 to Jan. 25 19 48
 and that I last saw him alive on Jan. 25 19 48

Immediate cause of death Acute Congestive
Heart Failure

Due to myocardial Infarct DURATION 5 days

Due to

Other conditions General Arterio -
Sclerosis
 (Include pregnancy within 3 months of death)

Major findings of operations. Date of op.

Autopsy results. PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of Injury Injured at work?

23. SIGNATURE Gedert B. Rude M. D. or other
 Address 3900 Military Rd. Date signed 1/26/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 29 1948
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

00686

1. PLACE OF DEATH

County Montgomery
City or town Linden, R.F.D.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Montg.
City or town Linden, rural
(If outside city or town limits, write RURAL and give nearest town)Street No. Silver Spring
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Denna Morris

3. (b) Social Security Number

4. Sex

F

5. Color or race

C

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Dec. 25, 1881

6. (c) If alive, give age

years

8. AGE:

Years 66Months 1Days 1

If less than one day

hrs.

min.

9. Birthplace

Madison Co. Va.
Town, county, and state

10. Usual occupation

Domestic

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 19 48, at md.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1 19 31, to Jan 27 19 48and that I last saw her alive on January 26 19 48

Immediate cause of death

Nephritis Chronic with
Edema

DURATION

4 year

Due to

Ammaurosis3 yrs.

Due to

Diabetes Mellitus6 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Webster Sewell, M.D.
M. D. or other

Address

Harbeck Rd.Date signed 1.30.48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 3 1948

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The corrected page is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00687 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 month
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 1 month

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D.C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4624 46th St., N.W.
 (If rural, give LOCATION)
 2. (a) If veteran, name war WWI

3. (a) FULL NAME

MORRIS, Robert John

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Hazel E. Morris
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Feb. 22, 1893
 8. AGE: Years 54 Months 11 Days 6 If less than one day _____ hrs. _____ min.

9. Birthplace Pa.
 (Town, county, and state)
 10. Usual occupation unknown
 11. Industry or business _____

FATHER 12. Name MORRIS, Hugh dec
 13. Birthplace Pa.
 MOTHER 14. Maiden name MC NEIL, Ann dec
 15. Birthplace Pa.

16. Informant Wife: Mrs. Hazel E. Morris
 Address 4624 46th St., N.W., Wash., D.C.
 17. burial Date thereof 2-2-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Arlington National
 Location Arlington, Va.

18. Funeral director Harry Donald DeVol
 Address 1241 Wis. Avenue, N.W., Wash., D.C.
 19. 1-28 19 48 Mary C. Patterson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 January 19 48 at 7:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 30 Dec. 19 47 to 28 Jan 19 48
 and that I last saw him alive on 28 Jan 19 48

Immediate cause of death Cerebral artery thrombosis DURATION approx 2 days

Due to arteriosclerosis

Due to _____

Other conditions B. coli septicaemia and meningitis ? 2 days
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results confirmed above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Manner of injury _____ Injured at work? _____

23. SIGNATURE R. D. Nies
R. D. NIES, Cdr. MC USN
 M. D. or other _____
 Address USNH Bethesda, Md. Date signed 1-28-48

RECEIVED

JAN 31 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

00688

223

1. PLACE OF DEATH:

County MontgomeryCity or town TAKOMA PARK
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 35 years

Hospital, institution, or street address where death occurred:

81 Columbia Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County MontgomeryCity or town TAKOMA PARK
(If outside city or town limits, write RURAL and give nearest town)Street No. 21 Columbia Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MUNROE, BENJAMIN HOLLOWAY Sr.

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Lillian Munroe6. (c) If alive, give age 64 years7. Birth date of deceased (mo., day, yr.) DEC 20, 18728. AGE: Years 75 Months 0 Days 22 It less than one day

hrs. min.

9. Birthplace Lake City, Florida
(Town, county, and state)10. Usual occupation draftsman11. Industry or business U.S. Pat. Off.12. Name Benjamin Hersey Munroe13. Birthplace Lynchburg, VA.14. Maiden name Jennie Bowen15. Birthplace Berryville, VA.16. Informant Munroe, Benjamin H. Jr.Address 2722 Colston Dr. Cherry Chase, Md.17. Examination Date thereof Jan. 15-1948
(Burial, cremation, or removal, When) (month) (day) (year)Cemetery or crematory H. LincolnLocation Gladesburg Rd. & Dial Lane, Prince Georges County, Md.18. Funeral director J. Arthur WaltersAddress 154 Carroll St. N.W. Wash. D.C.19. Jan. 13, 1948 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 12, 1948 at 6:35 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 12, 1947 to Jan 12, 1948and that I last saw him alive on January 11, 1948Immediate cause of death Acute Cardiac Failure

DURATION

Due to Generalized ArteriosclerosisDue to Primary site: prostate (1948)

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Alan H. Harding MDAddress 113 Carroll St. N.W. Wash. D.C. Date signed 1-12-48

RECEIVED

JAN 16 1948

SECRET

1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00689

Reg. Dist. No.

276

1. PLACE OF DEATH:

County MontgomeryCity or town Kenwood, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs.

Hospital, institution, or street address where death occurred:

906 Dorset Ave.How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty MontgomeryCity or town Kenwood

(If outside city or town limits, write RURAL and give nearest town)

Street No. 906 Dorset Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME

Frances C. Netherland

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Dr. Frank B. Netherland(deceased)

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.) December 21, 1906

8. AGE:

41

Years

41

Months

0

Days

12

If less than one day

_____ hrs.

_____ min.

9. Birthplace Bluefield West, Va.

(Town, county, and state)

10. Usual occupation Housewife11. Industry or business None12. Name Arthur E. Campbell13. Birthplace Patrick County, Va.14. Maiden name Fannie Mae Cobb15. Birthplace Roceland, N. C.16. Informant Glady Lee Campbell SecretaryAddress Steuert, Va.17. Burial Jan. 6, 1948

(Burial, cremation, or removal, Which?)

Date thereof (month) (day) (year)

Cemetery or crematory Arlington National CemeteryLocation Arlington, Va.18. Funeral director W. Keenan ThompsonAddress Bethesda, Maryland19. 1-5-48

(Date rec'd by registrar)

19

Wm E Jones

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 3 1948 at 2:00 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Sept and Exam case 1948 to 1948and that I last saw him alive on _____ 1948

Immediate cause of death

Hemorrhage due to bullet wound thru skull (Suicide)

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 1-3-48Where did injury occur? Kenwood Montg Md

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) homeMeans of injury Pistol wound Injured at work? no23. SIGNATURE Frank J. Borchert M.D.

M. D. or other

Address Chatham City Md Date signed 1-3-48

DURATION

short

RECEIVED
JAN 8 1948
BUREAU OF

Evidence for change of
parents' name, shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00690

128

FILM No. G 115 MAY 6 - 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 1 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Rx D.C. County Washington
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 88 Myrtle St., N.E.
(If rural, give LOCATION)
2. (a) If veteran, name war WWII ✓

3. (a) FULL NAME

Sears Wrtze Nicholas

3. (b) Social Security Number

4. Sex male 5. Color or race Col. 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) November 5, 1925 6. (c) If alive, give age 19 years

8. AGE: Years 22 Months 1 Days 27 It less than one day hrs. min.

9. Birthplace N.C.
(Town, county, and state)

10. Usual occupation unknown

11. Industry or business

12. Name Nicholas, Leoro Lois Alston

13. Birthplace N.C.

14. Maiden name AUSTIN, Lois Leoro Nichols

15. Birthplace N.C.

16. Informant Miss Leoro Nicholas

Address 88 Myrtle St., N.E., Wash., D.C.

17. burial Date thereof 1-6-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Virginia

18. Funeral director W. Ernest Jarvis

Address 1432 U. St., NW, Wash., D.C.

19. 1-2 148 Mary C. Patterson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 January 1948, at 9 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 29 Dec. 1947, to 2 Jan 1948
and that I last saw him alive on 2 Jan 1948

Immediate cause of death Caneratitis, acute DURATION 5 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results acute hemorrhagic pancreatitis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. A. DINSMORE, Jr. Lt. Cdr. MCUSN

M. D. or other

Address USNH Bethesda, Md. Date signed 1-2-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 6 1948

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Friendship Heights
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 45 years

Hospital, institution, or street address where death occurred:

200 Wootton Avenue,How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Friendship Heights
(If outside city or town limits, write RURAL and give nearest town)Street No. 200 Wootton Avenue

(If rural, give LOCATION)

None

2.(a) If veteran, name war

3.(a) FULL NAME

Henry Wootton Offutt

3.(b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed6.(b) Name of husband or wife Florence G. Offutt

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 2, 18628. AGE: Years 85 Months 10 Days 13 If less than one day
hrs. min.9. Birthplace Montgomery County Maryland
(Town, county, and state)10. Usual occupation Retired11. Industry or business None12. Name Thomas Offutt13. Birthplace Maryland14. Maiden name Mary J. Hill15. Birthplace Maryland16. Informant Lucy Lee MourningAddress Friendship Heights, Maryland17. Burial Date thereof February 2/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Oak HillLocation Washington, D. C.18. Funeral director Wm. Ransom RumphreyAddress Bethesda, Maryland19. Feb 2 19 48 Wm E Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30, 19 48, at 8:15 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 19 47 to Jan. 30 19 48
and that I last saw him alive on Jan. 29, 19 48

Immediate cause of death

Carcinoma of prostate and bladder

DURATION

2 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm E Jones M. D. or otherAddress 6911 5th St. NW Date signed Jan. 30/48

RECEIVED
FEB 4 1948
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1258

00692

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County _____City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 24 R Street, N.E.

(If rural, give LOCATION)

2. (a) If veteran, name War WWI ✓

3. (a) FULL NAME

OLIVER, Sidney Douglas

3. (b) Social Security Number

4. Sex

male

5. Color or race

Col

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Ella S. Oliver7. Birth date of deceased (mo., day, yr.) June 17, 19118. AGE: Years 36 Months 6 Days 21 If less than one day _____ hrs. _____ min.9. Birthplace S.C.

(Town, county, and state)

10. Usual occupation Unknown

11. Industry or business

12. Name OLIVER, James dec13. Birthplace S.C.14. Maiden name GORDON, Florence dec15. Birthplace S.C.16. Informant wife: Mrs. Ella S. OliverAddress 24 R St., N.E., Wash., D.C.17. burial Date thereof _____ (month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory _____

Location Charlotte, N.C.18. Funeral director W. Ernest JarvisAddress 1432 U St., N.W., Wash., D.C.19. 1-9- 48 Mary C. Patterson Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

2D. DATE OF DEATH January 8 1948 6:50P M21. I CERTIFY that death occurred on the date above stated; that it ended deceased from7 January 1948 8 January 1948and that I last saw him in alive on 8 January 1948

Immediate cause of death

Due to CholeraDue to uremiaDue to Hepatitis, Acute

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results Hepatitis, Acute; Choleraic nephrosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where) _____

Means of injury _____ - Injured at work? _____

23. SIGNATURE W. A. Dinsmore, Jr. LCDR MC USNAddress USNH Bethesda, Md. 1-9-48

Date signed _____

RECEIVED

JAN 10 1948

BUREAU

RECEIVED

JAN 22 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

107

00694

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH: Montg Co,
County.....
City or town..... Clarksburg. MD. (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 Weeks
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Maryland..... County..... Montgomery.....
City or town..... Clarksburg, Md. Rural.....
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2. (a) If veteran, name war.....

3. (a) FULL NAME James Edward Payne

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
6. (b) Name of husband or wife.....
6. (c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.) Jan 16th 1946
8. AGE: Years 1 Months 11 Days 29 If less than one day
..... hrs. min.

9. Birthplace Big Stone Gap, Va.
(Town, county, and state)
10. Usual occupation.....
11. Industry or business.....
FATHER 12. Name Edward C. Payne
13. Birthplace Exeter, Va.
MOTHER 14. Maiden name Myrtle Dickson
15. Birthplace Bigrock Va,

16. Informant Edward C. Payne
Address Clarksburg Md,
17. Burial Date thereof 1 17 48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetary or crematory Clarksburg Cemetery
Location Clarksburg. Md,
Ernest C Gartner
18. Funeral director Gaithersburg Md,
Address

19. Jan 17 48 Chas W G Goble
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15 1948 at 9:00 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dep med. Exam 19 to 19
and that I last saw h. alive on 19

Immediate cause of death Broncho-pneumonia
Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

DURATION

24 hrs?

Major findings of operations..... Date of op.....
Autopsy results Same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank J. Brochert M.D.
Dep med. Exam M. D. or other
Address Gaithersburg Md Date signed 1-15-48

RECEIVED

JAN 20 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

00695

214

1. PLACE OF DEATH:

County MontgomeryCity or town Kensington
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

~~XXXXXXXXXX~~ street address where death occurred:75 Connecticut Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Kensington
(If outside city or town limits, write RURAL and give nearest town)Street No. 75 Connecticut Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war no

3. (a) FULL NAME

TERESA A. PETTY

3. (b) Social Security Number

none

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband ~~XXXX~~ Joseph A.

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

April 13th. 1878

8. AGE:

Years

Months

Days

If less than one day

69822

hrs.

min.

9. Birthplace Washington, D. C.

(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name Eugene King Stewart13. Birthplace Wash. D. C.14. Maiden name Elizabeth Williams15. Birthplace Wash. D. C.16. Informant Mr. Kent PettyAddress 75 Conn. Ave. Kensington, Md.17. Burial Date thereof Jan. 8th. 48.

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Mt. OlivetLocation Washington, D. C.18. Funeral director Warner E. HumphreyAddress Silver Spring, Md.19. Jan. 7 19 48 Jarvis M. Schaeffer

(Date rec'd by registrar)

(Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 5 19 48 at 9:21 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 1 19 47, to Jan 5 19 48and that I last saw her alive on Jan 5 19 48

Immediate cause of death

Pneumo-pneumonia

DURATION

4 daysDue to coldDue to General debility
Pneumonia

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

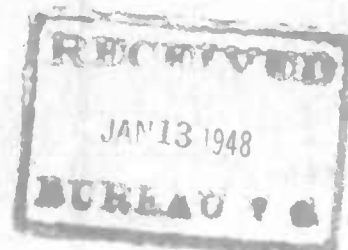
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John E. Hunter M.D.

M. D. or other

Address 3323 O St. N.W. Date signed 1/6/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County... Montgomery
 City or town... Bethesda
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 years
 Hospital, institution, or street address where death occurred:
4706 Rosedale Avenue
 How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Montgomery
 City or town... Bethesda
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4706 Rosedale Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war No

3. (a) FULL NAME

GEORGE H. PRICE

3. (b) Social Security Number

577-30-6858

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Gertrude D.
 6.(c) If alive, give age 62 years
 7. Birth date of deceased (mo., day, yr.) October 17, 1885
 8. AGE: 62 Years 3 Months 1 Days --- hrs. --- min.

9. Birthplace Virginia
 (Town, county, and state)
 10. Usual occupation Office Manager-Air Duct
 11. Industry or business
 12. Name James M. Price
 13. Birthplace Virginia
 14. Maiden name Julia Templeman
 15. Birthplace Virginia

16. Informant David G. Whitten
 Address 4706 Rosedale Ave., Bethesda, Md

17. Burial Date thereof Jan. 21, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Glenwood Cemetery
 Location Washington, D. C.

18. Funeral director W.M. Ransom Humphrey
 Address Bethesda, Maryland

19. Jan. 19, 1948
 (Date rec'd by registrar) Registrar 9pm E Jones

MEDICAL CERTIFICATION

20. DATE OF DEATH January 15, 1948 at 10:25 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942 to 1948
 and that I last saw him alive on Jan 15, 1948
 Immediate cause of death Coronary heart disease DURATION 10 years
 Due to Chronic myocarditis
 Due to Coronary atherosclerosis
 1942
 Other conditions hypertension
 (Include pregnancy within 3 months of death)

Major findings of operations no Date of op. ---

Autopsy results ---
 PHYSICIAN: Please underwrite the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide --- Date of ---
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE W. H. Jones M. D. or other
 Address 1832 E. Jones Date signed 1/15/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 22 1948

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 48 yrs.

Hospital, institution, or street address where death occurred:

429 Willard AvenueHow long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)Street No. 429 Willard Avenue,
(If rural, give LOCATION)2.(a) If veteran, name war No

3. (a) FULL NAME

Julia Vincenze Reynolds

3. (b) Social Security Number

None

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Married</u>
-------------------------	----------------------------------	---

6.(b) Name of husband or wife Edwin Clarke Reynolds6.(c) If alive, give age 79 years7. Birth date of deceased (mo., day, yr.) June 18, 1868

8. AGE:	Years	Months	Days	If less than one day
<u>79</u>		<u>6</u>	<u>27</u>hrs.min.

9. Birthplace Washington, D. C.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business None12. Name Lewey C. Solyom13. Birthplace Poland14. Maiden name Sarah J. Good15. Birthplace Maryland16. Informant Mr. Edwin LouisAddress 429 Willard Avenue, (Above)17. Cremation Date thereof Jan. 17, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Cedar Hill CrematoryLocation Washington, D.C.18. Funeral director Wm. Ransom ThompsonAddress Bethesda, Maryland19. 1/16/48 19.....
(Date rec'd by registrar)

Register

MEDICAL CERTIFICATION

20. DATE OF DEATH January 15th, 19 48 at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 1, 19 48 to Jan 15, 19 48
and that I last saw her alive on Jan 15, 19 48

Immediate cause of death

acute congestive heart failure

DURATION

1 hr.

Due to

chr. Corneo-vascular degeneration

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. G. Bauersfeld in J.
Bethesda, Md. M. D. or other 1/16/48
Address..... Date signed

AMERICAN MEDICAL ASSOCIATION

WASHINGTON, D. C.

RECEIVED

JAN 22 1948

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00698

216

Reg. Dist. No.

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 yrs., 2 months, 18 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 5 yrs., 2 mon. 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2900 Conn. Avenue, N.W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war WWI

3. (a) FULL NAME

RICHARDS, George (n) Major General USMC Ret.

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Lydia Richards
 7. Birth date of deceased (mo., day, yr.) February 6, 1872 8. (c) If alive, give age _____ years
 8. AGE: Years 75 Months 11 Days 3 If less than one day _____ hrs. _____ min.
 9. Birthplace Ohio
 (Town, county, and state)
 10. Usual occupation Retired Marine Corps
 11. Industry or business _____
 12. Name RICHARDS, Samuel dec.
 13. Birthplace Wash., D.C.
 14. Maiden name WESTLAKE, Laura dec.
 15. Birthplace Ky.

16. Informant wife: Mrs. Lydia Richards
 Address 2900 Conn. Avenue, N.W., Wash., D.C. Apt. 414
 17. burial Date thereof 1 12 48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Arlington National
 Location Arlington, Va.
 18. Funeral director S. H. HINES P. W. G.
 Address 2901 14th St., N.W., Wash., D.C.
 19. 1-9- 48 Mary C. Patterson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 January 19 48 at 8:45A M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 21 42 to 9 Jan 48
 and that I last saw h. im alive on 9 January 19 48
 Immediate cause of death Cerebral Thrombosis DURATION 8 days
 Due to Generalized Arteriosclerosis 5 yrs
 Due to Hypertension Arterial 9 yrs
 Other conditions Bronchopneumonia 4 da
Thrombosis Coronary Artery 5 yrs
 (Include pregnancy with its result) Hemiplegia 5 yrs
 Major findings of operations _____ Date of op. _____
 Autopsy results None
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE T. E. JARRETT, Jr., Cdr. MC USN
 Address USNH Bethesda, Md. Date signed 1-9-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs

Hospital, institution, or street address where death occurred:

5512 Charles StreetHow long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda, Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5512 Charles Street

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME

Willa Emma M. Riely

3. (b) Social Security Number

None4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single6. (b) Name of husband or wife None7. Birth date of deceased (mo., day, yr.) January 17, 18758. AGE: Years 72 Months 11 Days 27 If less than one day

hrs. min.

9. Birthplace Virginia

(Town, county, and state)

10. Usual occupation Housekeeper11. Industry or business Home12. Name Wm. A. Riely13. Birthplace Virginia14. Maiden name Virginia Swann15. Birthplace Virginia16. Informant Mrs. Vernon R. SmithAddress 9066 Seneca La., Bethesda, Md.17. Burial on Jan. 16, 1948

(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Zion Episcopal Ch. Cem.Location Charles Town, West Virginia18. Funeral director Wm. Ransom RumphreyAddress 7557 Wisconsin AvenueBethesda, Md. Wm B Jones19. (Date rec'd by registrar) 1/16/48 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14, 1948 at 2:45 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 20, 1947 to Jan. 14, 1948and that I last saw him alive on Dec. 13, 1947Immediate cause of death Serious illness DURATION 30 minInfarctionDue to Heart failure 5 yrsDue to InternalOther conditions -

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm B Jones M. D. or otherAddress 3921 Livingston St. N.E. Date signed 1/14/48

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE OF NEW YORK

RECORDED
JAN 20 1948
BUREAU 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, in correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

00700

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2003 9th St., N.W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war WWI

3. (a) FULL NAME

RILEY, Vincent Strauther Garfield

3. (b) Social Security Number

4. Sex male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) May 8, 1881 6. (c) If alive, give age _____ years

8. AGE: Years 66 Months 8 Days 18 It less than one day _____ hrs. _____ min.

9. Birthplace Va.
 (Town, county, and state)

10. Usual occupation unknown

11. Industry or business _____

12. Name RILEY, ?
 13. Birthplace unknown

14. Maiden name Mary ?
 15. Birthplace unknown

16. Informant cousin: Mrs. Martha Johnson
 Address 2003 9th St., N.W., Wash., D.C.

17. burial Date thereof 1-29-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Arlington National
 Location Arlington, Va.

18. Funeral director W. Ernest Jarvis
 Address 1432 U St., N.W., Wash., D.C.

19. 1-26 48 Mary C. Patterson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 January 19 48 at 3:30 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 23 January 48 to 26 January 19 48
 and that I last saw him alive on 26 January 19 48

Immediate cause of death _____

uremia
urinary extravasation
due to urethral stricture

Due to _____

Other conditions Diabetes

(Include pregnancy within 3 months of death)

Major findings of operations above confirmed
 Date of op. _____

Autopsy results Confirmed
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE P. L. Bates
P. L. BATES, Lt. (jg) MC USN
 M. D. or other _____

Address USNH Bethesda, Md. Date signed 1-26-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

00701
277

1. PLACE OF DEATH:

County Montgomery
 City or town Olney
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 year
 Hospital, institution, or street address where death occurred:
Home of Mrs Duley
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Montgomery
 City or town Olney
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 90 Mxs
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

MARY WILEY ROBISON

3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife PHILIP W. ROBISON7. Birth date of deceased (mo., day, yr.) Sept 22 18678. (c) If alive, give age 80 years

8. AGE: Years 78 Months 4 Days 20 If less than one day
 hrs. min.

9. Birthplace Charlotte, North Carolina
 (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name William L. Wiley13. Birthplace Virginia14. Maiden name Helen V. Wiley15. Birthplace Virginia16. Informant Mrs Dale RobisonAddress Sandy Spring Md

17. Burial Date thereof Jan 12 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Wood SideLocation Brinklow Md18. Funeral director Rev W. BarkerAddress Gettysville Md19. Jan 12 1948 Gertrude B. Tawler

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 Jan 1948 at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
1 Nov 1947 to 10 Jan 1948
 and that I last saw him ex alive on 5 Jan 1948

Immediate cause of death Coronary Occlusion DURATION 15 days

Due to Arteriosclerotic Heart Disease 30 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

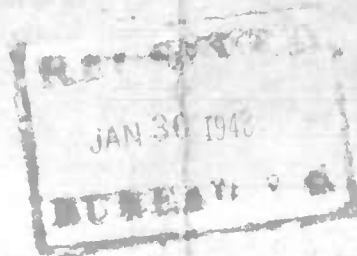
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles H. Ligon MD M. D. or otherAddress Sandy Spring Md Date signed 10 Jan '48

UNITED STATES DEPARTMENT OF HEALTH

CENTRAL BUREAU OF DEATHS



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Since birth 1-7-48Hospital, institution, or street address where death occurred: Suburban Hospital 4607 Maple Avenue
8600 Old Georgetown Rd, Bethesda Md.How long in hospital or institution? Since birth 1-7-48

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)Street No. 4607 Maple Avenue
(If rural, give LOCATION)2. (a) If veteran, name war None

3. (a) FULL NAME

James William Royal

3. (b) Social Security Number

None

4. Sex

m

5. Color or race

w

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife None

7. Birth date of deceased (mo., day, yr.)

Jan - 7, 1948

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

12

hrs.

min.

9. Birthplace

Suburban Hospital - Bethesda Md.
(Town, county, and state)

10. Usual occupation

None

11. Industry or business

None

FATHER

12. Name

William Aldrich Royal

13. Birthplace

Johnston Co. N. Carolina

MOTHER

14. Maiden name

Viola Baines

15. Birthplace

Danville Va.

16. Informant

William Aldrich Royal

Address

4607 Maple Avenue, Bethesda, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Jan. 21, 1948
(month) (day) (year)

Cemetery or crematory

Cedar Hill Cemetery

Location

Washington, D. C.

18. Funeral director

Wm. Paulsen Humphrey

Address

Bethesda, Maryland

19.

(Date rec'd by registrar)

19

48Wm E Jones
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan - 19 - 1948 at 11:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 10 1948 to Jan 20 1948
and that I last saw him alive on Jan 18 1948

Immediate cause of death

Cardiac failure

DURATION

Due to

Due to

Other conditions

New Born

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. D. Jones
6900 Wisconsin Ave
Cherry Chase Md

M. D. or other

Address

Date signed Jan 20 1948

RECEIVED
JAN 28 1948
ST. LOUIS MO

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D.C. County _____
 City or town WASHINGTON
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3514 34th St., N.W.
 (If rural, give LOCATION)
 2. (a) If veteran, name war WWI & WWII

3. (a) FULL NAME

SAVAGE, Eli, Major USMC Ret. Inactive

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Mary Savage
 7. Birth date of deceased (mo., day, yr.) Feb. 18, 1886
 6. (c) If alive, give age _____ years
 8. AGE: Years 61 Months 10 Days 15 If less than one day _____ hrs. _____ min.

9. Birthplace Ala.
 (Town, county, and state)
 10. Usual occupation Ret. Marine Corps
 11. Industry or business _____
 12. Name SAVAGE, ?
 13. Birthplace unknown
 14. Maiden name unknown
 15. Birthplace unknown

16. Informant wife: Mrs. Mary Savage
 Address 3514 34th St., N.W., Wash., D.C.
 17. burial Date thereof 1-6-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Arlington National
Arlington, Va.
 Location _____
 18. Funeral director S. H. HINES R. W. Gray
 Address 2901 14th St., N.W., Wash., D.C.
Mary C. Patterson
 19. 1-2- 48 Mary C. Patterson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 January 19 48 at 8:20 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 30 Dec. 19 47 to 2 Jan 19 48
 and that I last saw him alive on 2 January 19 48

Immediate cause of death _____ DURATION _____

Cerebral hemorrhage 12-29-48
 Due to Reported to have fallen
in his home
 Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

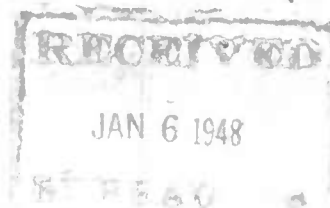
Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide accident Date of 12-29-48
 Where did injury occur? Washington D.C.
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) home
 Means of injury fall Injured at work? no
Frank J. Broschart M.D.
 23. SIGNATURE Frank J. Broschart, M.D.
Gaithersburg, Md. M. D. or other
Deputy Medical Examiner 1-2-48
 Address _____ Date signed _____



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

00704

216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban Hospital - Bethesda Md.How long in hospital or institution? 3 1/2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)Street No. 613 Sligo Ave.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Mrs. Sophia D. Scherrer

3. (b) Social Security Number

NONE

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife William F. Scherrer Dec.

7. Birth date of deceased (mo., day, yr.)

June 26, 1877

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

7070

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

ADOLF Koepper

13. Birthplace

Einbeck Germany

14. Maiden name

Karolina Wilttram

15. Birthplace

Einbeck Germany

16. Informant

Carl E. Scherrer (Son)

Address

613 Sligo Ave., Silver Spring Md.

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

Jan. 23, 1948

Cemetery or crematory

Cedar Hill

Location

Suitland, Md.

18. Funeral director

Wanner E. Pumphrey

Address

Silver Spring, Md.

19.

Jan 28 1948

(Date registered)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26, 1948 at 5:45 A.M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 9-20-48 to 1-26-48and that I last saw him alive on 1-25-48Immediate cause of death Cerebral Hemorrhage 4 daysTerminal Lobar Pneumonia 48 hoursDue to Chronic Passive Congestion Lungs 8 daysChronic Malignant Hypertension 10 years

Due to

Other conditions Chronic Nephritis 4 years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. SheenAddress 805 Woodbury Dr. Silver Spring Md. Date signed 1-26-48

RECEIVED

FEB 2 1948

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Emb. 144

00705

Reg. Dist. No. 223

1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Signature of physician

23. SIGNATURE

M. D. or other

Address

Date signed

RECEIVED

JAN 22 1948

ST. PAUL, V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00706

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County P.G.
 City or town Greenbelt
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4 F Crescent Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war WWII ✓

3.(a) FULL NAME

SHORR, Henry

3.(b) Social Security Number

4. Sex male 5. Color or race Jewish 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Selma Shorr
 7. Birth date of deceased (mo., day, yr.) April 8, 1915
 6.(c) If alive, give age _____ years
 8. AGE: Years 32 Months 9 Days 20 It less than one day _____ hrs. _____ min.
 9. Birthplace N.Y. (Town, county, and state)
 10. Usual occupation Government Employee
 11. Industry or business Social Security Board
 12. Name SHORR, Sam dec.
 13. Birthplace Rumania
 14. Maiden name Greenburg, Anna dec.
 15. Birthplace Rumania

16. Informant wife: Mrs. Selma Shorr
 Address 4 F Crescent Road, Greenbelt, Md.
 17. burial Date thereof 1-28-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Arlington National
 Location Arlington, Va.
 18. Funeral director Danzansky Funeral Home
 Address 3501 14th St., N.W., Wash., D.C.
myrl C. Callison
 19. 1-28 48 Mary C. Patterson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28 19 48 at 7:55A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 23 January 19 48, to 28 Jan 19 48
 and that I last saw him alive on 19

Immediate cause of death _____

Bronchopneumonia 4 days
 Due to chronic myelogenous leukemia 1 yr
 Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results were permitted Date of op. _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury car Injured at work? _____

23. SIGNATURE R. L. FLECK, Lt. MC USN M. D. or other _____

Address USNH Bethesda, Md. Date signed 1-28-48

RECEIVED
JAN 30 1948
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County MontgomeryCity or town Olney
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 13 daysHospital, institution, or street address where death occurred:
Montgomery San HospHow long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Parkville
(If outside city or town limits, write RURAL and give nearest town)Street No. Darkestown Drive
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME

Addie Agnes Sirk

3.(b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female white Widow

6.(b) Name of husband or wife Isaac Van Sirk

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) September 12, 18888. AGE: Years Months Days If less than one day
59 3 29 hrs. min.9. Birthplace Virginia
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Mr. Armisted Butler13. Birthplace Virginia14. Maiden name Miss Agnes James15. Birthplace Virginia16. Informant Hospital record

Address

17. Burial Date thereof Jan. 13-48
(Burial, cremation, or removal. Which) (month) (day) (year)Cemetery or crematory Flower Hill Church Cem.Location Redlands, Maryland18. Funeral director Wm. Huber & HumphreyAddress Bethesda, Maryland19. Jan 12 1948 Gertrude B Lawler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/11/48 1948 at 5 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12/29/47 1947, to 1/11/48 1948and that I last saw him alive on 1/10/48 1948

Immediate cause of death

Acute cardiac dilatationDUE TO chronic indolentDURATION 2 day

DUE TO

DUE TO

DUE TO

DUE TO

DUE TO

DUE TO

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DUE TO



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH

County MontgomeryCity or town Chesapeake
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 mo

Hospital, institution, or street address where death occurred:

7104 Meadow Lane

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Cal CountyCity or town New Port Beach
(If outside city or town limits, write RURAL and give nearest town)Street No. 2631 Crestview Dr.
(If rural, give LOCATION)2. (a) If veteran, name war World War #2

3. (a) FULL NAME

Clifton
H. Com. James C. Small

3. (b) Social Security Number

4. Sex male 5. Color or race W 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Peterson Small6. (c) If alive, give age 32 years7. Birth date of deceased (mo., day, yr.) Apr 8 19118. AGE: Years 36 Months 8 Days 25 If less than one day
hrs. min.9. Birthplace Indra, Okla.
(Town, county, and state)10. Usual occupation naval officer11. Industry or business U.S. Navy12. Name SMALL, John Clay13. Birthplace Texas14. Maiden name HUGHES, Maud Nina Edmondson15. Birthplace Texas16. Informant Patricia Small, WifeAddress 7104 Meadow Lane, Chesapeake Md17. burial Date thereof 1-6-48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Arlington NationalLocation Arlington, Va.18. Funeral director W. W. ChambersAddress 1400 Chapin St., N.W., Wash., D.C.19. 1-5 48 Mary C. Patterson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 3 1948 at 11:00 P.M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dep med Exam case to 19and that I last saw him alive on 19Immediate cause of death Coronary occlusionDue to Coronary occlusionDue to Coronary occlusionOther conditions Coronary occlusion

(Include pregnancy within 8 months of death)

Major findings of operations Coronary occlusionDate of op. 1-3-48Autopsy results Dep med Exam case

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Dep med Exam case Date of 1-3-48Where did injury occur? Dep med Exam case (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Dep med Exam caseMeans of injury Dep med Exam case Injured at work?23. SIGNATURE Frank J. Brockett M.D. M. D. or otherAddress Dep med Exam case Date signed 1-3-48

RECEIVED

JAN 6 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The content age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

00709

223-

1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

For street address where death occurred:
414 Hancock Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)Street No. 414 Hancock Ave.
(If rural, give LOCATION)2.(a) If veteran, name war no

3. (a) FULL NAME

MILDRED L. SOMERS

3. (b) Social Security Number

579-28-3040

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband Joseph S.7. Birth date of deceased (mo., day, yr.) June 30th. 1898

8. AGE: Years Months Days If less than one day

4964hrs.min.9. Birthplace Catonsville, Md.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name William McGoigan

13. Birthplace

14. Maiden name Della

15. Birthplace

16. Informant Mr. Joseph S. SomersAddress 414 Hancock Ave. Takoma Pk. Md.17. Burial Date thereof Jan. 7th. 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery Arlington NationalLocation Arlington Co. Virginia.18. Funeral director Wm. E. RumphreyAddress Silver Spring, Md.19. Jan 6 19 48 J. William Dodd
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 4 19 48 at 6:30 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 24 19 47 to Dec 29 19 47 and that I last saw h. RR alive on Dec 29 19 47Immediate cause of death Acute Coronary OcclusionDue to Coronary fibrillationDue to 2 weeks

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place, (where?)

Means of injury Injured at work?

23. SIGNATURE James P. RichardAddress 7717 Alshaker Dr. WDate signed 1-5-48

This Certificate signed
with knowledge & permission
of Dr. Broekart.

J. J. Richardson + J. D.

RECEIVED

JAN 8 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

942
00710
216

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore
CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:

6115 Brookeville Road,How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)Street No. 6115 Brookville Road

(If rural, give LOCATION)

None

2.(a) If veteran, name war

3. (a) FULL NAME

* * * * * ELIZA JANE SONNEMANN * * * * *

3. (b) Social Security Number

NONE

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

MEDICAL CERTIFICATION

2D. DATE OF DEATH January 1st, 1948 at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19..... to19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death.....

DEP. MED. EXAM. CASE

DURATION

DiedDue to Coronary OcclusionSuddenly

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

Frank J. Brumbaugh M.D.
Dep. Med. Exam.

M. D. or other

Address Gaithersburg, Md.Date signed 1/1/48

3. (a) FULL NAME

* * * * * ELIZA JANE SONNEMANN * * * * *

3. (b) Social Security Number

NONE

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

MEDICAL CERTIFICATION

2D. DATE OF DEATH January 1st, 1948 at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19..... to19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death.....

DEP. MED. EXAM. CASE

DURATION

DiedDue to Coronary OcclusionSuddenly

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

Frank J. Brumbaugh M.D.
Dep. Med. Exam.

M. D. or other

Address Gaithersburg, Md.Date signed 1/1/48

3. (a) FULL NAME

* * * * * ELIZA JANE SONNEMANN * * * * *

3. (b) Social Security Number

NONE

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

MEDICAL CERTIFICATION

2D. DATE OF DEATH January 1st, 1948 at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19..... to19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death.....

DEP. MED. EXAM. CASE

DURATION

DiedDue to Coronary OcclusionSuddenly

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

Frank J. Brumbaugh M.D.
Dep. Med. Exam.

M. D. or other

Address Gaithersburg, Md.Date signed 1/1/48

3. (a) FULL NAME

* * * * * ELIZA JANE SONNEMANN * * * * *

3. (b) Social Security Number

NONE

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

MEDICAL CERTIFICATION

2D. DATE OF DEATH January 1st, 1948 at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19..... to19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death.....

DEP. MED. EXAM. CASE

DURATION

DiedDue to Coronary OcclusionSuddenly

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

Frank J. Brumbaugh M.D.
Dep. Med. Exam.

M. D. or other

Address Gaithersburg, Md.Date signed 1/1/48

3. (a) FULL NAME

* * * * * ELIZA JANE SONNEMANN * * * * *

3. (b) Social Security Number

NONE

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

MEDICAL CERTIFICATION

2D. DATE OF DEATH January 1st, 1948 at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19..... to19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death.....

DEP. MED. EXAM. CASE

DURATION

DiedDue to Coronary OcclusionSuddenly

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

Frank J. Brumbaugh M.D.
Dep. Med. Exam.

M. D. or other

Address Gaithersburg, Md.Date signed 1/1/48

3. (a) FULL NAME

* * * * * ELIZA JANE SONNEMANN * * * * *

3. (b) Social Security Number

NONE

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

MEDICAL CERTIFICATION

2D. DATE OF DEATH January 1st, 1948 at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19..... to19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death.....

DEP. MED. EXAM. CASE

DURATION

DiedDue to Coronary OcclusionSuddenly

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

Frank J. Brumbaugh M.D.
Dep. Med. Exam.

M. D. or other

Address Gaithersburg, Md.Date signed 1/1/48

3. (a) FULL NAME

* * * * * ELIZA JANE SONNEMANN * * * * *

3. (b) Social Security Number

NONE

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

MEDICAL CERTIFICATION

2D. DATE OF DEATH January 1st, 1948 at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19..... to19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death.....

DEP. MED. EXAM. CASE

DURATION

DiedDue to Coronary OcclusionSuddenly

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

Frank J. Brumbaugh M.D.
Dep. Med. Exam.

RECEIVED
JAN 8 1948
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

00711

223-

1. PLACE OF DEATH:

County MINTSOMERY
 City or town TAKOMA PARK, MARYLAND
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7-26-47 TO 1-1-48
 Hospital, institution, or street address where death occurred:
MRS JOLIFFE'S NURSING HOME
805 MAPLE AVE, TAKOMA PARK, MD.
 How long in hospital or institution? ABOUT 5 MONTHS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MARYLAND County PRINCE GEORGES
 City or town CHEYERLY, MD.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5820 CARLYLE ST.
 (If rural, give LOCATION)
 2.(a) If veteran, name war ☒

3. (a) FULL NAME

DAVID SPELLMAN

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALE WHITE WIDOWER

6. (b) Name of husband or wife FANNIE LEVY
6. (c) If alive, give age DECEASED7. Birth date of deceased (mo., day, yr.) ABOUT 1 YR. AGO8. AGE: Years Months Days If less than one day
ABOUT 81 - - - hrs. - min.9. Birthplace RUSSIA
(Town, county, and state)10. Usual occupation TAILOR11. Industry or business TAILORING12. Name MORRIS SPELLMAN13. Birthplace RUSSIA14. Maiden name RUTH HANTMAN15. Birthplace RUSSIA16. Informant ADELAIDE C. COLVERAddress 805 MAPLE AVE, TAKOMA PARK, MD.

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Kansas City, Mo.Location Golding Funeral Home18. Funeral director W 17-9th St. NWAddress Jan 1 4819. (Date rec'd by registrar) 19. John Dool

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-1-48 at 12:15 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1, 1947 to 1-1-48
and that I last saw him alive on 1-1-48Immediate cause of death Acute Cardiac Failure

DURATION

Due to Terminale Bronchopneumonia

Due to

Other conditions
(Include pregnancy within 8 months of death)Major findings of operations
Date of op.Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dean H. Harding M.D.Address 113 Center St NW Date signed 1-5-48

RECEIVED
JAN 6 1948
RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157e

00712

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 day 9 hoursHospital, institution, or street address where death occurred:
Washington Sanitarium and Hosp.How long in hospital or institution? 1 day 9 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Takoma Park, Md. County MontgomeryCity or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)Street No. 706 Flower Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Unnamed Infant girl Spicer, Emma Lee

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

—

6. (b) Name of husband or wife

—

6. (c) If alive, give age years

—

7. Birth date of deceased (mo., day, yr.)

Jan 12, 1948

8. AGE:

Years

Months

Days

If less than one day

19 hrs.min.

9. Birthplace

Washington San Ed Hosp
Town, county, and state

10. Usual occupation

—

11. Industry or business

—

FATHER

12. Name

John Henry Spicer

13. Birthplace

Canton N.C.

MOTHER

14. Maiden name

Ruby Jean Sack

15. Birthplace

Montgomery Co.

16. Informant

San. Records

Address

Takoma Park Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Jan 15, 1948
(month) (day) (year)

Cemetery or crematory

George Washington Memorial Cemetery

Location

Rt. 1, Gaithersville, Md.

18. Funeral director

J. Arthur Walters

Address

254 Carroll St. NW, Takoma Park, Md.

19.

Date rec'd by registrar

Jan 15, 48

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 14, 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1/12 1948 to 1/14 1948and that I last saw he alive on 1/14 1948

Immediate cause of death

chronic anoxemia

DURATION

Due to congenital defect of ventricular septum

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results congenital defect

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Emma Hughes M.D.

M. D. or other

Address Takoma Park, Md. Date signed 1-14-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECORDED
JAN 16 1948
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50A

00713

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MONT.
City or town BETHESDA
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 mos.
Hospital, institution, or street address where death occurred:
Landon School - Wilson LA.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State PHILA County
City or town PA.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2310 - SPRUCE ST.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

AARS ELSIE LEE SPRING

3. (b) Social Security Number

222-10-3162

4. Sex F. 5. Color or race W 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1885

8. AGE: Years 62 Months Days It less than one day hrs. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual occupation Special Worker

11. Industry or business A. Soc. Prot. of Children

12. Name W. M. T. SPRING

13. Birthplace Balto., Md.

14. Maiden name Amanda Webb

15. Birthplace Richmond, Va

16. Informant Mrs Mary Lee Banfield

Address Landon School

17. Burial Date thereof 1-8-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematorium Druid Ridge

Location Lakesville, Md

18. Funeral director Joseph Lawler's Sons

Address 1756 Penna. Ave. N.W.

19. Jan 6 19 48 9pm E. Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6 19 48 at 7:45 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Supt. 19 47 to Jan 6 19 48
and that I last saw her alive on 1-6 19 48

Immediate cause of death Cancer Breast & metastases DURATION 2 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Geo. A. Hoffman M. D. or other

Address 1912 - Q St N.W. Date signed 1/6/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECORDED
JAN 8 1948
LHO 7 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

County Montgomery
 City or town Rockville (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Rockville (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

(NOR)

Mort Stevenson

3. (b) Social Security Number

4. Sex m 5. Color or race col 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) Jan 27 1878 8. (c) If alive, give age _____ years

8. AGE: Years 69 Months 0 Days 11 It less than one day _____ hrs. _____ min.

9. Birthplace Rockville md
 (Town, county, and state)

10. Usual occupation laborer

11. Industry or business _____

12. Name Edward Stevenson13. Birthplace Rockville md14. Maiden name Cassie Wallace15. Birthplace Maryland16. Informant Josephine LancasterAddress Takoma Park, Md.17. Burial Date thereof Jan. 12, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lincoln ParkLocation Rockville, Md.18. Funeral director Robert P. SnowdenAddress 246 N. Wood St. Rockville19. 1-12 48 EP Simpson

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 8 1948, at ? A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep med exam case 1948 to 1948 and that I last saw him alive on 1948

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Moans of injury _____ Injured at work? _____

23. SIGNATURE Frank J. Bernhart M.D. M. D. or otherAddress Washington, Md. Date signed 1-12-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

 93d 00715 716
 Reg. Dist. No.

1. PLACE OF DEATH:

 County Montgomery
 City or town Bethesda
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban Hospital
 How long in hospital or institution? 7 weeks, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

 State Maryland County Montgomery
 City or town Bethesda
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4509 Highland Ave.
 (If rural, give LOCATION)
2. (a) If veteran, name war none

3. (a) FULL NAME

Mr. Samuel Benjamin Strickler

3. (b) Social Security Number

578-10-5381
 4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Mrs. Susie b. Strickler
 7. Birth date of deceased (mo., day, yr.) Sept. 30, 1885 8. (c) If alive, give age 62 years

 8. AGE: Years 62 Months 3 Days 28 It less than one day hrs. min.
9. Birthplace Luray, Virginia
(Town, county, and state)10. Usual occupation Bus operator11. Industry or business Capital Transit12. Name Samuel Wellington Strickler13. Birthplace Pennsylvania14. Maiden name Martha S. Tingen15. Birthplace Virginia16. Informant Son Mr. Benton Wellington Strickler
 Address 6121 Western Ave., Chevy Chase, Md.
 17. Burial Date thereof Jan. 23, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Amissville Church CemeteryLocation Amissville, Virginia18. Funeral director Wm. Ransom Rumpsey
 Address Bethesda, Maryland
 19. Jan. 21, 1948 Registrar M E Jones
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 20, 1948 at 1:00 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/29 1947, to 1/20 1948
 and that I last saw him alive on 1/19 1948

 Immediate cause of death Acute heart failure with pulmonary edema
 Due to Coronary Thrombosis with cardiac infarct DURATION 9 hours

 Due to Bacterial subacute heart disease 7 weeks
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

 22. VIOLENCE: If death was due to external causes, till in the following:
 Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Benjamin Strickler, MD M. D. or other
 Address Bethesda, Md. Date signed 1/20/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

00716

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda, rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 day
 Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland
 How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1009 11th Street, Northwest
 (If rural, give LOCATION)
 2. (a) If veteran, name war WW I and II

3. (a) FULL NAME

THAMM, John James

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced divorced
 6. (b) Name of husband or wife _____
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) 11 November 1898
 8. AGE: Years 49 Months 2 Days 19 If less than one day _____ hrs. _____ min.

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 January 19 48 at 10:55P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1-30- 19 48, to 1-30- 19 48
 and that I last saw h. im alive on 1-30- 19 48

Immediate cause of death Thrombosis Coronary Artery DURATION 12 hrs?

Due to Coronary Heart Disease, Arteriosclerotic indef.

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results none performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE H. R. COOPER, LT MC USN M. D. or other _____

Address USNH, Bethesda, Md. Date signed 1-31-48

9. Birthplace Pennsylvania (Town, county, and state)
 10. Usual occupation Section Manager
 11. Industry or business Hecht Co., Silver Springs, Md.
 12. Name John Thamm
 13. Birthplace New York, deceased
 14. Maiden name Florence Belding
 15. Birthplace Pennsylvania, deceased
 16. Informant Sister: Mrs. Mary E. Moore
 Address 7 H Crescent Road, Greenbelt, Maryland
 17. Burial Date thereof _____ (month) (day) (year)
 (Burial, cremation, or removal. Which?) _____
 Cemetery or crematory Arlington National Cemetery
 Location Arlington, Virginia
 18. Funeral director W. W. Chambers Co.
 Address 1400 Chapin St., NW, Washington, D.C.
Mary C. Patterson
1-30 19 48 Registrar
 (Date rec'd by registrar)

RECEIVED
FEB 3 1948
ST. HELENS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00717

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 month, 26 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 1 month, 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State D.C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 7408 Alaska Avenue, N.W.
 (If rural, give LOCATION)
 2. (e) If veteran, name war Peace Time Veteran ✓

3. (a) FULL NAME

VANDEN HEUVEL, John Arie

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Gertrude L. Vanden Heuvel

7. Birth date of deceased (mo., day, yr.) July 20, 1884 6. (c) If alive, give age _____ years

8. AGE: Years 63 Months 5 Days 18 If less than one day _____ hrs. _____ min.

9. Birthplace Michigan
 (Town, county, and state)
Accountant

10. Usual occupation

11. Industry or business

12. Name VANDEN HEUVEL, Harry J. dec.13. Birthplace Holland14. Maiden name De BEER, Marie dec.15. Birthplace Holland16. Informant Wife: Mrs. Gertrude L. VandenHeuvelAddress 7408 Alaska Avenue, N. W., Wash., D.C.17. burial Date thereof 1-12-48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington NationalLocation Arlington, V.18. Funeral director W. W. CHAMBERS a.p.Address 1400 Chapin St. N.W. Wash. D.C.19. Jan. 8 48 Mary C. Patterson

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8 19 48 at 6:05A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
November 13 19 47 to January 8 19 48
 and that I last saw him alive on 8 January 19 48

Immediate cause of death Carcinoma Esophagus
 DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. A. Murphy, Comdr. MC USNAddress USNH Bethesda, Md. Date signed 1-8-48

RECEIVED

JAN 10 1948

BUREAU V C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00718

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH: Montgomery.
 County Takoma Park
 City or town (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
239 PARK AVE
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Montgomery
 City or town Takoma Park
 (If outside city or town limits, write RURAL and give nearest town)
 Street No 239 Park Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME X. CORDELLE WALTERS

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband W. B. Walters
 7. Birth date of deceased (mo., day, yr.) APRIL 1, 1875 6. (c) If alive, give age years
 8. AGE: Years 72 Months 9 Days 25 If less than one day hrs. min.

9. Birthplace Laurel, Ohio (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business James
 12. Name DEL HOUSER
 13. Birthplace Laurel, Ohio
 14. Maiden name Lina FATHER
 15. Birthplace Unk.

16. Informant WILLARD BRUCE WALTERS
 Address 239 PARK AVE., TAKOMA PARK, MD.
 17. Burial Date thereof JAN. 29, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Rock Creek Cemetery
 Location Washington, D.C.
 18. Funeral director J. Walter Walters
 Address 1254 Carroll St. Takoma Park
 19. Jan 26 19 48 Registrar

MEDICAL CERTIFICATION

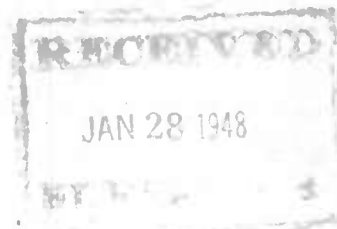
20. DATE OF DEATH Jan 26 - 1948 19 48 at 2:5 PM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 17 19 45 to Jan 26 19 48
 and that I last saw him alive on Jan 26 19 48
 Immediate cause of death Cerebral Hemorrhage
 Due to Hypertension
Heart Disease
 Due to arteriosclerosis
 Other conditions

DURATION

(Include pregnancy within 3 months of death)
 Major findings of operations none
 Date of op.
 Autopsy results ✓
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide ✓ Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE W. B. Walters M.D. M. D. or other
1334 Mass Ave N.W. Date signed Jan 26 48

also Treated by.
Dr Charles Holahan
5th & Underwood St N.W.
Dr Frank Williamson
Conn ore N.W.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00719

217

Reg. Dist. No. 191

1. PLACE OF DEATH:

County.....*Montgomery*
 City or town.....*Ellicott City*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....*54 days*
 Hospital, institution, or street address where death occurred.....*Montgomery Gen Hosp*
 How long in hospital or institution?.....*31 days*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*Md* County.....*Howard*
 City or town.....*Ellicott City* Rural.....*Ellicott City*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....*Ellicott*
 (If rural, give LOCATION).....*✓*
 2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex.....*M* 5. Color or race.....*C* 6.(a) Single, married, widowed, or divorced.....*Widower*
 6.(b) Name of husband or wife.....*Fannie Warfield*
 7. Birth date of deceased (mo., day, yr.).....*1857*
 6.(c) If alive, give age..... years
 8. AGE: Years.....*91* Months..... Days..... If less than one day..... hrs. min.

9. Birthplace.....*Maryland*
 (Town, county, and state)
 10. Usual occupation.....*Farm Laborer*
 11. Industry or business.....
 12. Name.....*Caleb Warfield*
 13. Birthplace.....*Md*
 14. Maiden name.....*Unknown*
 15. Birthplace.....

16. Informant.....*George Warfield*
 Address.....*411 Fairmount Ave. Towson Md*
 17. Burial.....*Burial* Date thereof.....*1-29-48*
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory.....*Locust Chapel*
 Location.....*Atholton Md*
 18. Funeral director.....*F. C. Higinbotham*
 Address.....*Ellicott City, Md*

19. Jan 28, 1948.....*John D. Longhman*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*1/25/48* at.....*2300 P.M.*
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....*12/4*.....*1948* to.....*1/25/48*.....*1948*
 and that I last saw him alive on.....*1/24/48*.....*1948*
 Immediate cause of death.....*Chronic Myocarditis*
 Due to.....*Gen arterio Sclerosis*
 Due to.....
 Other conditions.....*Sanguis left leg.*
 (Include pregnancy within 3 months of death)
 Major findings of operations.....*Sanguis*
Thrush Ampulata Date of op.....*12/23/47*
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?.....

23. SIGNATURE.....*John B. Longhman* M. D. or other.....
 Address.....*Sandy Sp. M.* Date signed.....*1/25/48*

RECEIVED

FEB 6 1948

11 61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County Montgomery
 City or town Takoma Park.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 hour 30 min.
 Hospital, institution, or street address where death occurred:
Washington. San. Hospital
 How long in hospital or institution? 1 hr 30 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md. County Montgomery
 City or town Kensington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 106. Conn. Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Bill Lance Warne.

3. (b) Social Security Number

4. Sex

M.

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

June 26 - 1944

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

36269

hrs.

50

min.

9. Birthplace

Saginaw, Mich.
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

none.

FATHER

12. Name

Martin R. Warne

13. Birthplace

Amboy, Ind

MOTHER

14. Maiden name

Helma Bird.

15. Birthplace

Noblesville, Ind.

16. Informant

Hosp. Record.

Address

Washington. San. Hosp. Takoma Park

17. (Burial, cremation, or removal, Which?)

Removal

Date thereof

1-5-48
(month) (day) (year)

Cemetery or crematory

Location

Rockville, Md.

18. Funeral director

Address

Bethesda, Md.

19. (Date rec'd by registrar)

Jan 5 - 48John D. ...
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

1/5/48

19.....

at

9:50

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July1947

to

1/5/48

19.....

and that I last saw him alive on

1/5/48

19.....

Immediate cause of death Toxemia

DURATION

Secondary to severe vomiting today

Due to

Due to

Other conditions

Asthma; Bronchial

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at

23. SIGNATURE

Samuel Allen M.D.

M. D. or other

Address

Kensington, Md

Date signed

RECEIVED

JAN 8 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00721

Reg. Diat. No. 223

1. PLACE OF DEATH:

County Montgomery
 City or town Takoma Park, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 years
 Hospital, institution, or street address where death occurred:
Washington Sanitarium & Hospital
 How long in hospital or institution? 6 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Montgomery County Montgomery
 City or town Takoma Park
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Minnie L. Weber

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Widow

6.(b) Name of husband or wife Conrad Weber7. Birth date of deceased (mo., day, yr.) Nov. 10, 18598. AGE: Years Months Days If less than one day
88 89 1 28 hrs. min.9. Birthplace Germany
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial Date thereof Jan. 11, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Jan 9 19 48
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-7 19 48 at 9:00 A.M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 19 41 to 1-7-48 and that I last saw her alive on 1-7-48Immediate cause of death Pneumonia - broncho DURATION TerminalDue to Congestive heart failure 2 wks

Due to _____

Other conditions Arteriosclerosis years

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

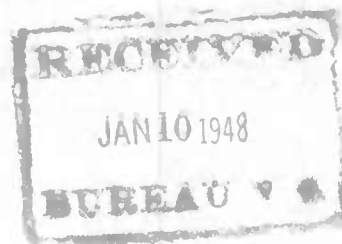
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert A. Hare MD M. D. or otherAddress Takoma Park, Md. Date signed 1/7/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

00722

93d

1. PLACE OF DEATH:

County MontgomeryCity or town Cabin John
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

MacArthur Blvd & Main StreetHow long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Cabin John
(If outside city or town limits, write RURAL and give nearest town)Street No. MacArthur Blvd. & Main Street
(If rural, give LOCATION)2. (a) If veteran, name war None

3. (a) FULL NAME

Mr. Hugh E. White

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Nellie M. White7. Birth date of deceased (mo., day, yr.) October 1, 1872
6. (c) If alive, give age 70 years

8. AGE:

Years

75

Months

3

Days

27

If less than one day

hrs. min.

9. Birthplace Unknown

(Town, county, and state)

10. Usual occupation U. S. Governen EmployeeNone

11. Industry or business

FATHER

12. Name John A. White13. Birthplace Indiana

MOTHER

14. Maiden name Sarah J. Mayhugh15. Birthplace Indiana16. Informant Mrs. Nellie M. WhiteAddress Cabin John, Maryland17. Burial Date thereof January 31/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rock Creek CemeteryLocation Washington, D. C.18. Funeral director Wm. Ruden HumphreyAddress Bethesda, Maryland19. Jan 31 1948 Wm E Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28, 1948, at 1:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

deed suddenly and that I last saw him alive on Nov. 15 1947

Immediate cause of death

Coronary occlusion

DURATION

1 hour

Due to

Chr. Cardiac-vascular

Due to

degeneration20 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

E. G. Bauerfeld M.D.

M. D. or other

Address Bethesda, Md. Date signed 1/29/48

This certificate completed by me by permission
of the Medical Examiner.
E. G. Bauerfeld Jr.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 212

1. PLACE OF DEATH:

County Montgomery
 City or town Rockesville B. I. D.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 yrs.
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County
 City or town Rural Retreat
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Rebecca Wingate

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed

8. (b) Name of husband or wife William Wingate

7. Birth date of deceased (mo., day, yr.) 1874 ?
 8. (c) If alive, give age _____ years

8. AGE: Years 73 ? Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Independence Va.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Thomas Baet13. Birthplace Va.14. Maiden name unknown

15. Birthplace

16. Informant Graves C. WingateAddress Rockesville, Md.17. Burial Date thereof 1-30-48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory MonocacyLocation Beallsville, Md.18. Funeral director Wm. B. HiltonAddress Barnesville, Md.19. 1-30 19 48 Charles W. Elgin
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 19 48 at 11:45 P.M.21. I CERTIFY that death occurred on the data above stated; that I attended deceased from Dec 27 19 48 to Jan 27 19 48and that I last saw him/her alive on Jan 25 19 48Immediate cause of death Compensatory heart failure - terminaluremiaDue to Arteriosclerotic cardiovascularDue to renal disease (3-6-48-45)

Other conditions

(Include pregnancy within 9 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. B. Hilton M. D. or otherAddress Rockesville, Md. Date signed 4/28/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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FEB 2 1948

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County..... Montgomery
 City or town..... Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 20 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution?..... 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... D.C. County.....
 City or town..... Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1610 R St., S.E.
 (If rural, give LOCATION)
 2. (a) If veteran, name war..... WWI

3. (a) FULL NAME

YOST, Harry James

3. (b) Social Security Number

4. Sex..... male
 5. Color or race..... W-US
 6. (a) Single, married, widowed, or divorced..... married
 6. (b) Name of husband or wife..... Ethyl C. Yost
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... May 7, 1896
 8. AGE: Years..... 51 Months..... 8 Days..... 7 If less than one day..... hrs. min.

9. Birthplace..... W. Va.
 (Town, county, and state)
 10. Usual occupation..... Electric Craneman
 11. Industry or business..... Navy Yard, Wash., D.C.
 12. Name..... YOST, Amost
 13. Birthplace..... W. Va.
 14. Maiden name..... PILES, Emma
 15. Birthplace..... W. Va.

16. Informant..... wife: Mrs. Ethyl C. Yost
 Address..... 1610 R St., S.E., Wash., D.C.
 17. burial - Shipped Date thereof..... Jan. 15, 1948
 (Burial, cremation, or removal, which?) (month) (day) (year)
 Cemetery or crematory..... Zion Cemetery
 Location..... Wheeling, W. Va.
 18. Funeral director..... W. W. CHAMBERS
 Address..... Georgetown, D.C. Wheeling, W. Va.
 19. 1-11 19 48 Mary C. Patterson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 14 January 19 48 at 8:53 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
26 Dec. 19 47 to 14 Jan. 19 48
 and that I last saw him in alive on 14 January 19 48
 Immediate cause of death..... Sarcotoma tuberosa

DURATION.....
 Due to..... Osteomyelitis Sarcotoma
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)
 Major findings of operations..... Osteomyelitis Sarcotoma
 Date of op. 2/18/48
 Autopsy results..... Same
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Boat Injured at work?
 23. SIGNATURE..... H. B. EISBERG, Cdr. MC USN
 M. D. or other
 Address..... USNHBethesda, Md. Date signed..... 1-14-48

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JAN 19 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information and state the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00725

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 day
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County St. M.
 City or town Patuxent River
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Naval Air Station, 731 D MEMQ
 (If rural, give LOCATION)
 2. (a) If veteran, name war ✓

3. (a) FULL NAME

ZANGS, Theresa Coy

3. (b) Social Security Number

4. Sex female 5. Color or race W-US 6. (a) Single, married, widowed, or divorced single
 6. (b) Name of husband or wife
 7. Birth date of deceased (mo., day, yr.) January 10, 1948 6. (c) If alive, give age 17½ years
 8. AGE: Years Months Days If less than one day 17½ hrs. min.

9. Birthplace Bethesda, Md.
 (Town, county, and state)
 10. Usual occupation
 11. Industry or business
 12. Name ZANGS, Leonard Joseph
 13. Birthplace Iowa
 14. Maiden name SHOEMAKER, Hazel Endora
 15. Birthplace Va.

16. Informant Fa: Mr. Leonard J. Zangs
 Address NAS Patuxent River, Md. (731 D MEMQ)
 17. burial Date thereof 1-11-48
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Arlington National
 Location Arlington, Va.

18. Funeral director W. W. CHAMBERS J. D. P.
 Address Georgetown, D.C.
 19. 1-14 48 Mary C. Patterson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 January 19 48 at 8:10 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 January 19 48 to 11 Jan 19 48
 and that I last saw h. er alive on 11 Jan 19 48
 Immediate cause of death Bronchopneumonia

DURATION

24 hrs

Due to
 Due to
 Other conditions Pleural effusion
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.
 Autopsy results Confirmed above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE PAUL PETERSON, Capt. MC USN
 M. D. or other
 Address USNH Bethesda, Md. Date signed 1-11-48

RECEIVED
JAN 19 1948
BUREAU T.M.

RECEIVED

FEB 3 1948

BUREAU